

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Montgomery		MARYLAND		STATE District of Columbia		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Bethesda Rural		LENGTH OF STAY OR (in this place) 14 days		CITY (If outside corporate limits, write RURAL and give nearest town) OR Washington, D.C.		47X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital				STREET ADDRESS (If rural give location) 4200 Cathedral Avenue, N. W.			
3. NAME OF DECEASED: (First) Arban (Middle) Jay (Last) ACKERMAN				4. DATE (Month) (Day) (Year) OF DEATH: January 12 1956			
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH: 8-22-04	9. AGE last birthday: 51 yrs.	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS.: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Architect		10B. KIND OF BUSINESS OR INDUSTRY: Industrial		11. BIRTHPLACE (State or foreign country): Tennessee		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME: Arban ACKERMAN				14. MOTHER'S MAIDEN NAME: Cary KEMP			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unk.) Yes (If Yes, give dates of service) WW II		16. SOCIAL SECURITY NO.: 085-07-2718		17. INFORMANT'S ADDRESS: Sister Mrs. Vivian SWANSON Same as above			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) Pulmonary Edema		Terminal
ANTECEDENT CAUSE (S) DUE TO Arteriosclerotic heart disease		Unknown
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. C.A. Tongue		7 mo
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19A. DATE OF OPERATION: 1/11/56	19B. MAJOR FINDINGS OF OPERATION: C.A. Tongue, Tonsil, Palate, Soft, Right c-trunk metastasis	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
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21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 28 Dec 1955 , to 12 Jan 56 , that I last saw the deceased alive on 12 Jan 56 , and that death occurred at 1513 M, from the causes and on the date stated above.		DATE SIGNED
SIGNATURE: R. L. KING		ADDRESS: R. A. Pumphrey Funeral Home

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF 17 Jan 1956	NAME OF CEMETERY OR CREMATORY Forest Hill Cemetery	LOCATION (City, town, or county) (State) Memphis, Tennessee
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DATE REC'D BY LOCAL REGISTRAR 13 Jan 1956	REGISTRAR'S SIGNATURE Mary E. Garrelly	24. FUNERAL DIRECTOR'S ADDRESS 7557 Wisconsin Avenue, Bethesda, Md.
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MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 16 1956

RECEIVED

744

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u> MARYLAND				STATE <u>District of Columbia</u> COUNTY			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Bethesda</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Washington</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center Bethesda, Maryland</u>				STREET ADDRESS (If rural give location) <u>1103 - 9th Street, N. W. Apt. 2</u>			
3. NAME OF DECEASED:		(First) <u>Iola</u>		(Middle) <u>Burnett</u>		(Last) <u>Adams</u>	
(Type or Print)						4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan. 22, 1956</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Separated</u>	8. DATE OF BIRTH: <u>March 27, 1904</u>		9. AGE last birthday <u>51</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>---</u>		11. BIRTHPLACE (State or foreign country): <u>District of Columbia</u>	
13. FATHER'S NAME: <u>James W. Adams</u>				14. MOTHER'S MAIDEN NAME: <u>Cordelia Cozzen</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY No. <u>None</u>		17. INFORMANT & ADDRESS: <u>The Medical Record, The Clinical Center</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Hepatic Coma</u>						<u>days</u>	
ANTECEDENT CAUSE (B) <u>Carcinoma of R/L breast</u>						<u>9+ mos.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>3 11-9</u>				19B. MAJOR FINDINGS OF OPERATION: <u>Hepatic metastases; Morrison pouch metastases</u>			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct. 14 1955</u> , to <u>Jan. 22 1956</u> , that I last saw the deceased alive on <u>Jan. 22 1956</u> , and that death occurred at <u>9:03 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Robert Austin Nihil</u>				ADDRESS <u>M.D. The Clinical Center, NIH, Bethesda, Md.</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-28-56</u>		NAME OF CEMETERY OR CREMATORY <u>Lincoln Mem. Cem.</u>		LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-23/56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>R. E. Jarvis</u>		ADDRESS <u>1432 Yonkers St. N.E.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 25 1956

RECEIVED

U.S. Bureau of Investigation
JAN 25 1956

CERTIFICATE OF DEATH

Reg. Dist. No. 216.....

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Montgomery	MARYLAND	STATE Md.	COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Kensington	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Kensington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 10707 Shaftsbury Street		STREET ADDRESS (If rural give location) 10707 Shaftsbury Street	
3. NAME OF DECEASED: (First) (Middle) (Last) Genevieve Ambush		4. DATE (Month) (Day) (Year) OF DEATH: Jan. 27, 1956	
5. SEX: Female	6. COLOR OR RACE: Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: Feb. 16, 1894
9. AGE last birthday 61 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): Barnesville, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: Charles E. Claggett		14. MOTHER'S MAIDEN NAME: Edmonia Ambush	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: Wm. T. Ambush 10707 Shasberry Street			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) Congestive Heart Failure			1 month
DUE TO (B) Carcinoma Breast (Right)			6 months
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Arteriosclerosis generalized			4 yrs.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: April 29/55		19B. MAJOR FINDINGS OF OPERATION: C. of Breast - Rt. & Benign Metastasis generalized	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 1953 , 19....., to 1/27, 19 56 , that I last saw the deceased alive on 1/26, 19 56 and that death occurred at 12 M, from the causes and on the date stated above.			
SIGNATURE Samuel M. D.		ADDRESS 10 A. N.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 1/31/56	
NAME OF CEMETERY OR CREMATORY Fairview Cemetery		LOCATION (City, town, or county) (State) Frederick, Md.	
DATE REC'D BY LOCAL REGISTRAR 1-30-56		REGISTRAR'S SIGNATURE Bessie M. Thompson	
24. FUNERAL DIRECTOR John T. Stewart		ADDRESS 30 H Street, N.E.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 2 1956

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

00700

Reg. Dist. No. 217

Item 7, File 9192 2-7-56 et

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Derwood</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Sandy Spring</u>	
TOWN <u>Derwood</u>		TOWN <u>Sandy Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Melinda Russell's Nursing Home</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Charles H. Aukward</u>		4. DATE OF DEATH (Month) <u>January</u> (Day) <u>29</u> (Year) <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>1/25/89</u>
9. AGE last birthday <u>67</u> yrs.		10. DATE OF BIRTH If under 1 year: Months <u>67</u> Days <u>29</u> Hours <u>29</u> Min. <u>1956</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Sandy Spring, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Presley Aukward</u>		14. MOTHER'S MAIDEN NAME <u>Lavinia Hill</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Emily Thomas, Sandy Spring, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

154X
Immediate cause(a) Secondary Anemia

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Carcinoma Prostatum(c) None

INTERVAL BETWEEN ONSET AND DEATH

3 mos1 year

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

None

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 12/10/53, 1953, to 1/29/56, 1956, that I last saw the deceased alive on 1/24/56, 1956, and that death occurred at 1/29/56, m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Buried</u>	<u>1/30/56</u>	<u>Rock Memorial</u>	<u>Sandy Spring</u>	<u>MD</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>1-31-56</u>	<u>Arthure B. Lawley</u>	<u>Robert L. Snowden</u>	<u>Road</u>	

RECEIVED

FEB 3 1956

BUREAU V. B.

747 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00701
CERTIFICATE OF DEATH Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rt. #2 Germantown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>		STREET ADDRESS (If rural give location) <u>1</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Charles William Barton</u>		4. DATE OF DEATH: (Month) (Day) (Year) <u>1 16 1956</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>W</u>	8. DATE OF BIRTH: <u>11-21-02</u>
9. AGE last birthday: <u>53</u> yrs.		IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS.: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY: <u>Farmer</u>	11. BIRTHPLACE (State or foreign country): <u>Virginia</u>
13. FATHER'S NAME: <u>Joseph Barton</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>no</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Fitzwater, C. F. - Germantown Md.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Congestive heart failure</u>			<u>1 day</u>
ANTECEDENT CAUSE (B) <u>Bronchiectasis & pulmonary fibrosis</u>			<u>? years</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Pulmonary tuberculosis arrested</u>			<u>? years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>16 Jan., 1956</u> , to <u>17 Jan., 1956</u> , that I last saw the deceased alive on <u>16 Jan., 1956</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>17 Jan 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR <u>1/18/56</u>		REGISTRAR'S SIGNATURE <u>Wakeman</u>	
24. FUNERAL DIRECTOR <u>V.L. Dellinger</u>		ADDRESS <u>woodstock Va.</u>	

BUREAU V. S.

JAN 20 1956

RECEIVED

737 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

Reg. Dist. No. 00702

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>D. C.</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Rockville</u>	LENGTH OF STAY (in this place) <u>21 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Washington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Brightview San.</u>		STREET ADDRESS (If rural give location) <u>3909 Huntington St. N.W.</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>FRANK</u>	(Middle) <u>Bradley</u>	(Last) <u>BELL</u>	
(Type or Print)		OF DEATH: <u>Jan. 24 19 56</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>7-10-1864</u>
9. AGE last birthday <u>91</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
		Months <u>6</u>	Days <u>14</u> Hours <u></u> Min. <u></u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Ret. Acct.</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Cornelius J. Bell</u>		14. MOTHER'S MAIDEN NAME: <u>Susan Bradley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS: <u>Mrs. E.R. Clark</u>		Daughter	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Bronchopneumonia</u>			<u>3 days</u>
ANTECEDENT CAUSE (B) <u>Emaciation inattention</u>			<u>4 mo.</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Senility</u>			<u>1 yr.</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Prostatic obstruction with indwelling catheter</u>			<u>2 1/2 yrs.</u>
19A. DATE OF OPERATION: <u>None</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		INJURY OCCURRED	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 1, 1953</u> to <u>Jan 24, 1956</u> , that I last saw the deceased alive on <u>Jan 23, 1956</u> , and that death occurred at <u>705 M.</u> from the causes and on the date stated above.			
SIGNATURE <u>W. H. Richwine</u>		DATE SIGNED <u>Jan 24, 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 27-56</u>	
NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		LOCATION (city, town, or county) (State) <u>Rockville Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/25/56</u>		24. FUNERAL DIRECTOR ADDRESS <u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



749

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY	Montgomery		STATE	District of Columbia	
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		
TOWN	Bethesda Rural	6 days	Washington, D.C.		
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS (If rural give location)		
U. S. Naval Hospital			1731 New Hampshire Avenue, N.W.		
3. NAME OF DECEASED:			4. DATE OF DEATH:		
(First)	(Middle)	(Last)	(Month)	(Day)	(Year)
(Type or Print)	Raymond	Edward	January	22	19 56
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR Months Days
Male	White	Married	11-28-83	72 yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):			10B. KIND OF BUSINESS OR INDUSTRY:		
Engineering			Management		
11. BIRTHPLACE (State or foreign country):			12. CITIZEN OF WHAT COUNTRY?		
Conn.			US		
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
George C. BELL			Mary E. HURBULT		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give year of dates of service)			16. SOCIAL SECURITY NO.		
Yes WW I			Unknown		
17. INFORMANT & ADDRESS:			18. MEDICAL CERTIFICATION		
Wife Mrs. Dalah R. BELL			Same as above		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (A)			Immediate		
ANTECEDENT CAUSE (B)			Immediate		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			7 days		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			3 yrs		
19A. DATE OF OPERATION:			19B. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY?			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		
			21C. WHERE DID (City or town) (County) (State)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		
			21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from 16 Jan, 1956, to 22 Jan, 1956, that I last saw the deceased alive on 22 Jan 1956, and that death occurred at 11:30P M, from the causes and on the date stated above.					
SIGNATURE ADDRESS DATE SIGNED					
B. S. YURICK, JR., MS USN U. S. Naval Hospital, NNMC, Bethesda, Maryland					
23. BURIAL, CREMATION, REMOVAL (SPECIFY)			24. FUNERAL DIRECTOR ADDRESS		
DATE THEREOF			NAME OF CEMETERY OR CREMATORY		
25 Jan 1956			Cedar Hill Crematroy		
CREMATION			Suitland, Maryland		
DATE REC'D BY LOCAL REGISTRAR			24. FUNERAL DIRECTOR ADDRESS		
24 Jan 1956			Chambers Funeral Home		
			3072 M Street, N.W. Washington, D.C.		

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STANDARD V. S.

1951

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death cleanly and legibly.

743 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00704

CERTIFICATE OF DEATH

Reg. Dist. No. 213

Item 8, Film 192 1-31-56 et

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Montgomery	MARYLAND	STATE California	COUNTY San Diego
CITY (If outside corporate limits, write RURAL and give nearest town) Bethesda Rural	LENGTH OF STAY (in this place) 9 mos; 16 dys	CITY (If outside corporate limits, write RURAL and give nearest town) La Jolla	
HOSPITAL OR INSTITUTION OR STREET ADDRESS USNH, NNM, Bethesda, Maryland		STREET ADDRESS (If rural give location) 6725 Muirlands Drive	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year) OF DEATH:	
(First) Willis	(Middle) Henry	(Last) BELTZ	January 17, 1956
5. SEX: Male	6. COLOR OR RACE: Caucasian	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 21 JAN 1897 1898
9. AGE last birthday: 57 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mariner		10B. KIND OF BUSINESS OR INDUSTRY: Mariner	
11. BIRTHPLACE (State or foreign country): Illinois		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME: Jeremiah BELTZ		14. MOTHER'S MAIDEN NAME: Mary SHAFER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give year or date of service) Yes WWI, 11, Korea		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT & ADDRESS: Mrs. Twilla C. BELTZ (Wife), 6725 Muirlands Dr., La Jolla, Calif.			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Adenocarcinoma, sigmoid			1 1/2 yrs
ANTECEDENT CAUSE (B) 2 metastases			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 1 April, 1955 , to 17 Jan, 1956 , that I last saw the deceased alive on 17 Jan, 1956 , and that death occurred at 8:20 PM , from the causes and on the date stated above.			
SIGNATURE E. J. RUPNIK		ADDRESS MC USNR, USNH, NNM, Bethesda, Md.	
DATE SIGNED 18 Jan 1956		DATE SIGNED 18 January 1956	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 20 Jan 1956	
NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		LOCATION (City, town, or county) (State) Arlington, Virginia	
DATE REC'D BY LOCAL REGISTRAR 18 Jan 1956		REGISTRAR'S SIGNATURE Mary E. Ganssely	
FUNERAL DIRECTOR B. A. Mumfery Funeral Home		ADDRESS 7557 Wisconsin Avenue, Bethesda, Md.	

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) Takoma Park, Md.
OR TOWN D.O.A.

HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington Sanitarium & Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) Takoma Park, Md.
OR TOWN 1113 Lancaster Rd. T. Park, Md.

STREET ADDRESS (If rural give location) TAKOMA PARK.

3. NAME OF DECEASED:

(First) Mason (Middle) Herbert (Last) Black

4. DATE (Month) (Day) (Year)
OF DEATH: 1-18 1956

5. SEX:

Male

6. COLOR OR RACE:

Cauc.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH:

Sept. 8, 1902

9. AGE last birthday 53 yrs.

IF UNDER 1 YEAR Months Days Hours Min.
9 54

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): glass worker Bureau of Standards

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Mahoning, Pennsylvania

12. CITIZEN OF WHAT COUNTRY? Citizen

13. FATHER'S NAME:

Herbert W. Black

14. MOTHER'S MAIDEN NAME:

Flora Cross

15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) no

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: 1113 Lancaster Rd. Mrs. Edith H. Black Takoma Park, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE

(A)

Acute Coronary Thrombosis

INTERVAL BETWEEN ONSET AND DEATH 30 min.

ANTECEDENT CAUSE (S)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B)

Coronary Heart Disease

8 years.

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID (City or town) (County) (State)
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While ☐ Not while ☐ at work ☐ at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 1955 to 18 JAN. 1956, that I last saw the deceased alive on Dec. 8, 1955, and that death occurred at 8 A M, from the causes and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Coroner, Montgomery County Ratified
and permission granted for me to issue
this certificate

A. J. Ruller

BUREAU V. S.

JAN 1

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: COUNTY <u>Montgomery</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> TOWN <u>Bethesda</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Liburban Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>D.C.</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> OR TOWN <u>Washington</u> STREET ADDRESS (If rural, give location) <u>3725 Malomb NW</u>	
3. NAME OF DECEASED: (Type or Print) <u>Julia</u> (First) <u>Blitstein</u> (Middle) (Last) (Type or Print)		4. DATE (Month) (Day) (Year) OF DEATH: <u>JAN.</u> <u>9</u> <u>1956</u>	
5. SEX: <u>Fe</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE. MARRIED. WIDOWED, DIVORCED. (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>JAN. 17, 1890</u>
9. AGE last birthday: <u>65</u> yrs.		10. MONTHS: <u>4</u>	11. DAYS: <u>9</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>-</u>	
11. BIRTHPLACE (State or foreign country): <u>List. of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Jacob Levinson</u>		14. MOTHER'S MAIDEN NAME: <u>Gannie Young</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>3713 MA 0000</u>	
17. INFORMANT & ADDRESS: <u>Miss Jeanne Blitstein - Wash. D.C.</u>			

16. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A)	<u>Carcinoma colon</u>	
ANTECEDENT CAUSE (B)	DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(B)	DUE TO
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION: <u>5</u>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 1, 1955, to Jan 9, 1956, that I last saw the deceased alive on Jan 9, 1956, and that death occurred at 4:10 P M, from the causes and on the date stated above.

SIGNATURE <u>Dr. Joseph Kinnick</u>	ADDRESS <u>6457 Wisconsin Ave, Bethesda, Md.</u>	DATE SIGNED <u>1/9/56</u>
23. BURIAL CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>1/11/56</u>	NAME OF CEMETERY OR CREMATORY <u>Washington Hebrew Congregational Wash. D.C.</u>
LOCATION (City, town, or county) (State)	24. FUNERAL DIRECTOR <u>S.H. Hines Co</u>	ADDRESS <u>2901 14th St. N.W. Wash. D.C.</u>
DATE REC'D BY LOCAL REGISTRAR <u>1/10/56</u>	REGISTRAR'S SIGNATURE <u>Bennie M. Thompson</u>	

W. A. DUNN

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

COUNTY Montgomery MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town) Olney LENGTH OF STAY (in this place) 1 day
 TOWN Olney
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Montgomery County General, Inc.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Howard
 CITY (If outside corporate limits, write RURAL and give nearest town) Clarksville
 OR TOWN Clarksville
 STREET ADDRESS (If rural give location) 13X-1

3. NAME OF DECEASED:

(First) (Middle) (Last)
Henrietta Katherine Boardley

4. DATE (Month) (Day) (Year)
 OF DEATH: January 5 1956

5. SEX:

Fe

6. COLOR OR RACE:

Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

married

8. DATE OF BIRTH:

February 2, 1901

9. AGE last birthday

54 yrs.

IF UNDER 1 YEAR

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME:

Henson Dorsey

14. MOTHER'S MAIDEN NAME:

Inez Gardner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS:

Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE

(A) Cerebral AccidentINTERVAL BETWEEN ONSET AND DEATH
24 hours.

ANTECEDENT CAUSE (S)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While ☐ Not while ☐ at work at work

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/4/56, 1956 to 1/5/56, 1956 that I last saw the deceased alive on 1/5/56, 1956, and that death occurred at 4:25P M, from the causes and on the date stated above.

SIGNATURE

C. Whitaker, M.D.

M.D.

Clarksville, Md.

DATE SIGNED

1/7/57

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

1/8/56

NAME OF CEMETERY OR CREMATORY

Locust Grove

LOCATION (City, town, or county)

Simpsonville, Md.

(State)

DATE REC'D BY LOCAL REGISTRAR

1-7-56

REGISTRAR'S SIGNATURE

Gertrude B. Lawler

24. FUNERAL DIRECTOR

F. C. Hengembootham, Ellicott City, Md.

MARGIN RESERVED FOR BINDING

JOHN J. V. S.

1914

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752

CERTIFICATE OF DEATH

Reg. Dist. No. 217...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
<u>X</u> <u>Olney</u>				<u>Silver Spring</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Montgomery County Gen., Inc.</u>				STREET ADDRESS (If rural give location) <u>Rt. #2</u>			
3. NAME OF DECEASED: (First) <u>Bert</u> (Middle) <u>Louis</u> (Last) <u>Bolden</u>				4. DATE (Month) <u>1</u> (Day) <u>14</u> (Year) <u>19 56</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>W.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>		8. DATE OF BIRTH: <u>12/28/76</u>	
9. AGE last birthday <u>79</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired</u>		11. BIRTHPLACE (State or foreign country): <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME: <u>Charles Bolden</u>				14. MOTHER'S MAIDEN NAME: <u>Lou Ingraham</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>Uremia</u>		<u>4 days</u>
ANTECEDENT CAUSE (B) <u>Chronic's Disease</u>		<u>1 year</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
--	--

19A. DATE OF OPERATION: <u>1</u>	19B. MAJOR FINDINGS OF OPERATION: <u>C</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
----------------------------------	--	---

21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/1/56 to 1/14/56 that I last saw the deceased alive on 1/14/56 and that death occurred at 11:35 M, from the causes and on the date stated above.

SIGNATURE [Signature] ADDRESS [Address] DATE SIGNED 1/14/56

23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>1-17-56</u>	NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
DATE REC'D BY LOCAL REGISTRAR <u>Jan 14-56</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>[Signature]</u>	ADDRESS <u>254 Carroll St. NW. Wash. D.C.</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 19 1956

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:

COUNTY **Montgomery** MARYLAND
 CITY (If outside corporate limits, write RURAL) LENGTH OF STAY
 OR and give nearest town) (in this place)
 TOWN **Bethesda Rural** **lmo 3 days**

HOSPITAL OR
 INSTITUTION OR
 STREET ADDRESS **U. S. Naval Hospital**

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **District of Columbia**
 COUNTY
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR
 TOWN **Washington, D.C.**

STREET ADDRESS (If rural give location)
3114 16th Street, N.E.

3. NAME OF DECEASED:

(First) (Middle) (Last)
Robert Stewart BONAR

4. DATE (Month) (Day) (Year)
 OF DEATH: **January 22 19 56**

5. SEX:

Male

6. COLOR OR RACE:

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

Married

8. DATE OF BIRTH:

3-6-92

9. AGE last birthday

63 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Civil Service

10B. KIND OF BUSINESS OR INDUSTRY:

U.S. Government

11. BIRTHPLACE (State or foreign country):

Washington, D.C.

12. CITIZEN OF WHAT COUNTRY?

US

13. FATHER'S NAME:

Robert BONAR

14. MOTHER'S MAIDEN NAME:

Elizabeth MC KERICHAR

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give year or dates of service)

Yes WW I

16. SOCIAL SECURITY NO.

None

17. INFORMANT & ADDRESS:

Son Mr. Robert S. BONAR Jr. Same as above

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE

(A)

Meningitis

ANTECEDENT CAUSE (B)

DUE TO

(B)

Arteriosclerotic

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(C)

Hypertensive cardiovascular disease approx 1 yr.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

INTERVAL BETWEEN ONSET AND DEATH

2 months**approx 1 year****approx 1 yr.**

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ **NO** ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While at work Not while at work

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **19 Dec, 1955** to **22 Jan, 1956**, that I last saw the deceased alive on **22 Jan 19 56**, and that death occurred at **9:05 AM**, from the causes and on the date stated above.

SIGNATURE **M. D. Willcutts, Jr.**

ADDRESS

DATE SIGNED

M. D. WILLCUTTS JR LTJG, MC USNR U. S. Naval Hospital, NNMC, Bethesda, Maryland

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

Burial**25 Jan 56****Arlington National Cemetery****Arlington, Virginia**

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

FUNERAL DIRECTOR

ADDRESS

22 Jan 1956**Frank P. Savelly****HINES Funeral Home****2901 14th Street, N.W. Washington, D.C.**

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

U.S. AIR FORCE

754

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Montgomery		MARYLAND		STATE Maryland		COUNTY Montgomery	
CITY (If outside corporate limits, write RURAL or and give nearest town) Bethesda Rural		LENGTH OF STAY (in this place) 2 days		CITY (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital				STREET ADDRESS (If rural give location) 12301 Atherton Drive			
3. NAME OF DECEASED:				4. DATE OF DEATH:			
(First) Patrick		(Middle) William		(Last) BOWEN		(Month) (Day) (Year) January 31 1956	
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single		8. DATE OF BIRTH: 1-29-56	
9. AGE last birthday 2 yrs.		10. AGE last birthday 2 yrs.		11. BIRTHPLACE (State or foreign country): Bethesda, Maryland		12. CITIZEN OF WHAT COUNTRY? US	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None				10B. KIND OF BUSINESS OR INDUSTRY: None		11. BIRTHPLACE (State or foreign country): Bethesda, Maryland	
13. FATHER'S NAME: James W. BOWEN				14. MOTHER'S MAIDEN NAME: Andrea T. WOODIN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No				16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS: Father LCDR James W. BOWEN USN Same as above	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) 751X Meningitis						1 day	
ANTECEDENT CAUSE (S) DUE TO Rupt meningococci						2 day	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Hydrocephalus - congenital							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 2		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 29 Jan., 1956 , to 31 Jan., 1956 , that I last saw the deceased alive on 31 Jan., 1956 , and that death occurred at 1:00P M, from the causes and on the date stated above.							
SIGNATURE Howard A. Pearson				ADDRESS		DATE SIGNED	
Howard A. PEARSON LT, MC, USN U. S. Naval Hospital, NNMC, Bethesda, Maryland							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		2 Feb 1956		Arlington National Cemetery		Arlington, Virginia	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
1 Feb 1956		Mary E. Parselly		W. E. Humphrey Funeral Home		Georgia Avenue, Silver Spring, Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3 1/2 DVAHIO

100

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00711

755

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>M</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Bethesda</u>		<u>6 days 10 hours</u>		TOWN <u>Rockville</u> <u>26</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>				STREET ADDRESS (If rural give location) <u>Normandy Farms</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>JAMES BROWN</u>				<u>1 - 13 1956</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>colored</u>	<u>Widower</u>	<u>6-23-75</u>	<u>80</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Gardner</u>				<u>North Carolina</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>UNKNOWN</u>				<u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>unk.</u>						<u>Mr. A. Bassett - Normandy Farms Rockville, Md.</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE				(A) <u>Cardiac failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u>	
ANTECEDENT CAUSE (B)				DUE TO <u>Acute pancreatitis</u>		<u>1 week</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(C) <u>undetermined</u>		<u>—</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>gen. arteriosclerosis</u>							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>12/8/1955</u> , to <u>1/13/1956</u> , that I last saw the deceased alive on <u>1/13/1956</u> , and that death occurred at <u>7:00 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Stephen H. Jones</u>				M.D. <u>Rockville, Md.</u>		DATE SIGNED <u>1/13/56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1-16-56</u>		<u>Lincoln Park</u>		<u>Rockville, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>1-16-56</u>		<u>Bennie M. Thompson</u>		<u>Robert L. Snowden</u>		<u>Rockville, Md.</u>	

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

712

00712

Reg. Dist. No. 223

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write OR and give nearest town) <u>Lake Park</u>		LENGTH OF STAY (in this place) <u>D.D.</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>Silver Spring</u>		OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. Sanatorium Hospital</u>				STREET ADDRESS (If rural, give location) <u>2706 Arcola</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) <u>Donald</u>		(Middle) <u>Lee</u>		(Last) <u>Browning</u>		(Month) (Day) (Year) <u>1-1-1956</u>	
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>Caucasian</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>2-?-56</u>	
9. AGE last birthday: <u>19</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Army</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Pvt.</u>		11. BIRTHPLACE (State or foreign country): <u>Charleston W. Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME: <u>?</u>			
14. MOTHER'S MAIDEN NAME: <u>Vivian Pennington</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes-Active Army</u>			
16. SOCIAL SECURITY No.: <u>-</u>				17. INFORMANT & ADDRESS: <u>Stephens - Mr. Simons - 2706 Arcola S.S. Md.</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause		(a) <u>Hemorrhage - massive internal</u>				15 min.	
Antecedent cause(s)		(b) <u>Communited fractures of Pelvis + Rt Femur</u>				15 min.	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		(c) <u>Auto-accident</u>				15 min.	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				21. DATE OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) <u>street</u>		21c. (City or town) (County) (State) <u>Silver Spring Montgomery Md.</u>		21d. HOW DID INJURY OCCUR? <u>Auto Accident</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Auto Accident</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>John B. Ball</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>1 Jan 1956</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Jan 4-1956</u>		NAME OF CEMETERY OR CREMATORY <u>Not Cemetery Ft Myer, Va</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. <u>Jan 1-1956</u>		REGISTRAR'S SIGNATURE <u>J. H. Dodder</u>		24. FUNERAL DIRECTOR <u>Prinibaldi Funeral Home</u>		ADDRESS <u>816 Ft. St N.E. Wash, D.C.</u>	



CERTIFICATE OF DEATH

Reg. Dist. No. 218

756

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Montgomery</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Montgo.</i>
CITY (If outside corporate limits, write OR and give nearest town) <i>Unity</i>	RURAL LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write OR and give nearest town) <i>Unity</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Brookville, P.O. #1</i>		STREET ADDRESS (If rural give location) <i>Brookville - P.O. #1</i>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(Type or Print) <i>Virginia Burkley</i>	(First) (Middle) (Last)	(Month) (Day) (Year)	
5. SEX: <i>Female</i>	6. COLOR OR RACE: <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <i>Widowed</i>	8. DATE OF BIRTH: <i>March 15, 1854</i>
9. AGE last birthday: <i>101</i> yrs.		10. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <i>Housekeeper</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>Home</i>	
11. BIRTHPLACE (State or foreign country): <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY: <i>U.S.A.</i>	
13. FATHER'S NAME: <i>Richard Higgs</i>		14. MOTHER'S MAIDEN NAME: <i>Fannie - unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <i>no</i>		16. SOCIAL SECURITY No.: <i>no</i>	
17. INFORMANT & ADDRESS: <i>Laura Howard, Brookville, Md. P.O. #1</i>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death
Immediate cause (a) <i>Arteriosclerotic cardiovascular disease</i>		<i>50 years</i>
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO		
(c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Rheumatoid arthritis</i>		<i>15 years</i>
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <i>Jan. 15, 1952</i> , to <i>Jan. 17, 1956</i> , that I last saw the deceased alive on <i>Jan. 16, 1956</i> , and that death occurred at <i>from the causes and on the date stated above.</i>		
SIGNATURE <i>James V. Kern M.D.</i>		DATE SIGNED <i>1/18/56</i>
ADDRESS <i>Homestead, Md.</i>		
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY
<i>Burial</i>	<i>1-21-56</i>	<i>Howard Chapel</i>
LOCATION (City, town, or county) (State)		
<i>Unity, Md.</i>		
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR
<i>Jan. 21-56</i>	<i>Charles E. Goble</i>	<i>Robert L. Snowden - Rockville, Md.</i>
		ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



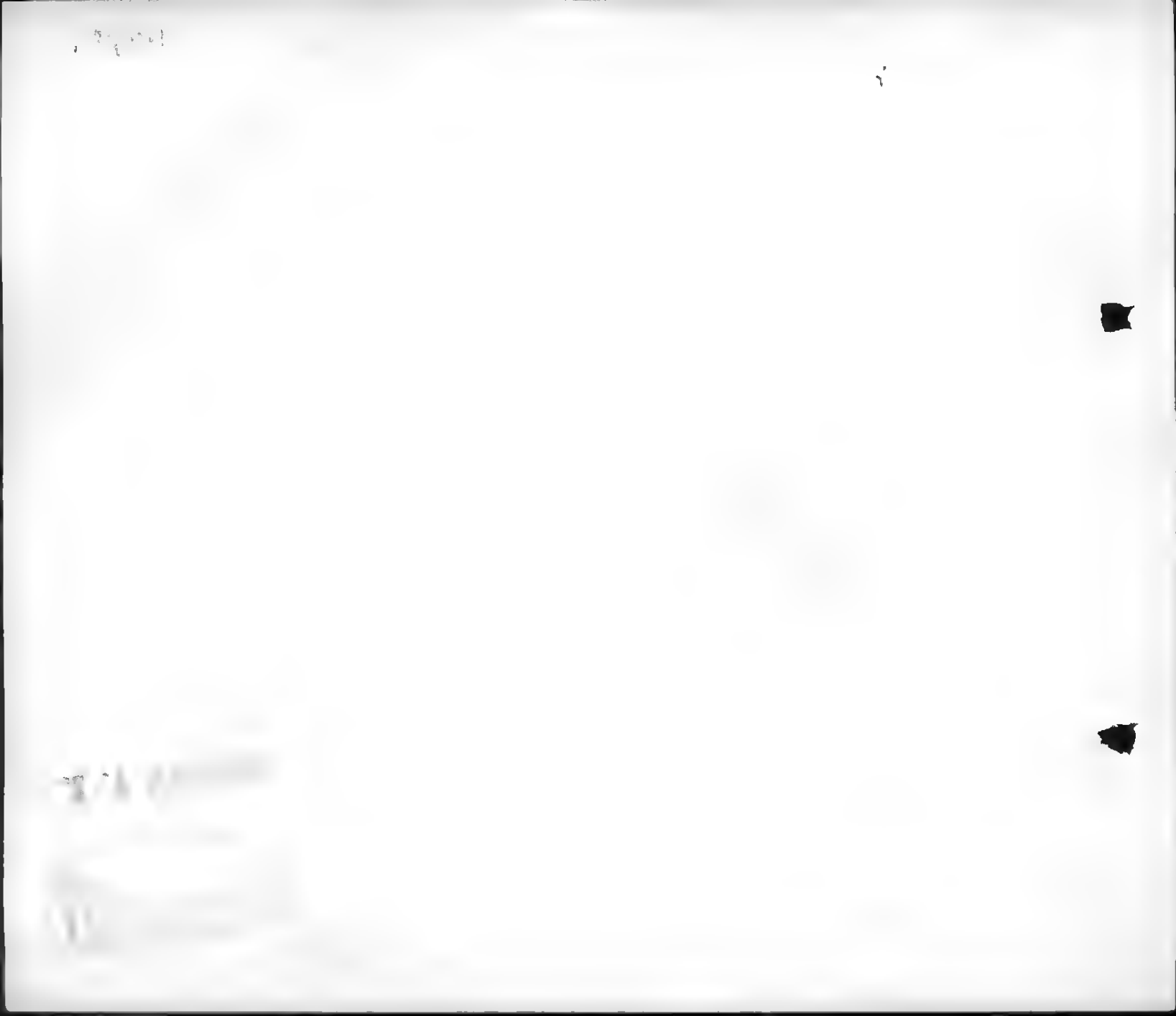
PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

757 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 007114

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Bethesda</u>		<u>13 years</u>		TOWN <u>Bethesda</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8614 Lancaster Drive</u>				STREET ADDRESS (If rural give location) <u>8614 Lancaster Drive</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
(Type or Print) <u>Louise E. BUTLER</u>				OF DEATH: <u>January 10, 1956</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>January 25,</u>	<u>88</u> yrs.	<u>11</u> Months	<u>15</u> Days	<u></u> Hours <u></u> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Pennsylvania</u>	
13. FATHER'S NAME: <u>Unknown</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown Margaret L</u>			
15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY No. <u>None</u>		17. INFORMANT & ADDRESS: <u>Mrs. Bragaw Daughter- 8614 Lancaster Dr. Beth Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>420.1</u>							
IMMEDIATE CAUSE (A) <u>Cornary thrombosis</u>							
DUE TO							
ANTECEDENT CAUSE (S) (B) <u>Hypertension</u>							
DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>January 10, 1955</u> , to <u>January 10, 1956</u> ; that I last saw the deceased alive on <u>2/12</u> , 1955, and that death occurred at <u>9:30 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>R. Joseph Lewis</u>				ADDRESS <u>M. D. 6450 Wisconsin Ave. Beth. Md</u>			
DATE SIGNED <u>1/12/56</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1-12-56</u>		<u>Ft. Lincoln</u>		<u>Prince Georges Md</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		FUNERAL DIRECTOR		ADDRESS	
<u>1/12/56</u>		<u>R. Joseph Lewis</u>		<u>Robert C. Humphrey</u>		<u>Bethesda Md</u>	



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00715

758

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>D. C.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Kensington</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Washington</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Carroll Hall Nursing Home</u>				STREET ADDRESS (If rural give location) <u>3411 20th St., N.E.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>JESSIE A. CAKE</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>JAN. 14</u> 19 <u>56</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>July 7, 1873</u>	9. AGE last birthday <u>82</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired homemaker - own home</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Washington, D. C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME: <u>Fanning Barnard</u>			
14. MOTHER'S MAIDEN NAME: <u>Linda Harvey</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>none</u>				17. INFORMANT & ADDRESS: <u>Mr. Lawrence Cake, 2500 Wisconsin Ave., N.W. Washington, D. C.</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>CARCINOMATOSIS</u>				DUE TO			
ANTECEDENT CAUSE (B) <u>SECONDARY TO MAMMARY CARCINOMA</u>				DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>DIABETIS MELLITIS</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>ARTERIOSCLEROTIC HEART DISEASE</u>							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION <u>NONE</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11-27, 1953</u> , to <u>1-14, 1956</u> , that I last saw the deceased alive on <u>1-14</u> , 19 <u>56</u> , and that death occurred at <u>6:00</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Francis J. Patter</u>				ADDRESS <u>5206 Norwood Dr. Chevy Chase, Md.</u>		DATE SIGNED <u>1-14-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/17/56</u>		NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-16-56</u>		REGISTRAR'S SIGNATURE <u>Francis J. Patter</u>		24. FUNERAL DIRECTOR <u>Warner E. Lumphrey, 8434 Ga. Ave. Silver Spring, Md.</u>			



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

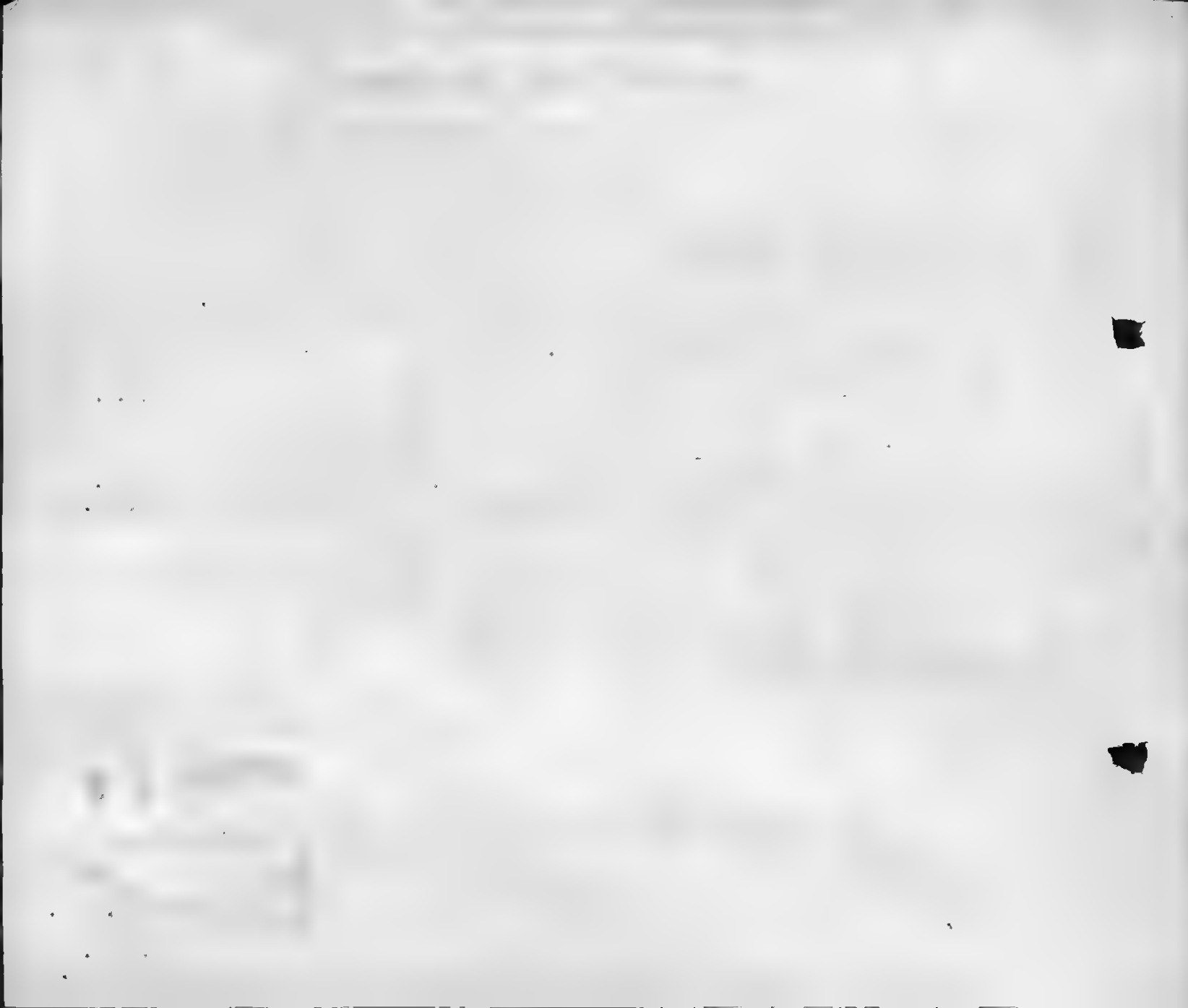
753

CERTIFICATE OF DEATH

00716

Reg. Dist. No. 216

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Montgomery</u>		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>1 1/2</u> days		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Silver Spring</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>				STREET ADDRESS (If rural give location) <u>2604 Avena Street</u>			
3. NAME OF DECEASED (First) <u>CLARA</u> (Middle) <u>MARTIN</u> (Last) <u>CALL</u>				4. DATE OF DEATH (Month) <u>JAN.</u> (Day) <u>17</u> (Year) <u>19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Feb. 29, 1884</u>	9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Greensboro, Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George F. Martin</u>				14. MOTHER'S MAIDEN NAME <u>Ann Blosser</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Mrs. Martha Labin, 2604 Avena St. Silver Spring, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420. IMMEDIATE CAUSE (A) _____				<u>Coronary Occlusion with</u>			
ANTECEDENT CAUSE(S) DUE TO _____				<u>Myocardial Infarction</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO _____				<u>Generalized Arteriosclerosis</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/10</u> , 19 <u>55</u> , to <u>1/17</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/17</u> , 19 <u>56</u> , and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above. SIGNATURE <u>John J. Curry</u> M.D. <u>11301 Georgia Ave.</u> DATE SIGNED <u>1/17/56</u> ADDRESS (Street, city, town, state)							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Trans. & Burial</u>		DATE THEREOF <u>1/19/56</u>		NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>		LOCATION (City, town, or county) (State) <u>Waynesburg, Greene Co., Pa.</u>	
24. REC'D BY REGISTRAR DATE <u>1-19-56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>		ADDRESS <u>8434 Ga. Ave. Silver Spring, Md.</u>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

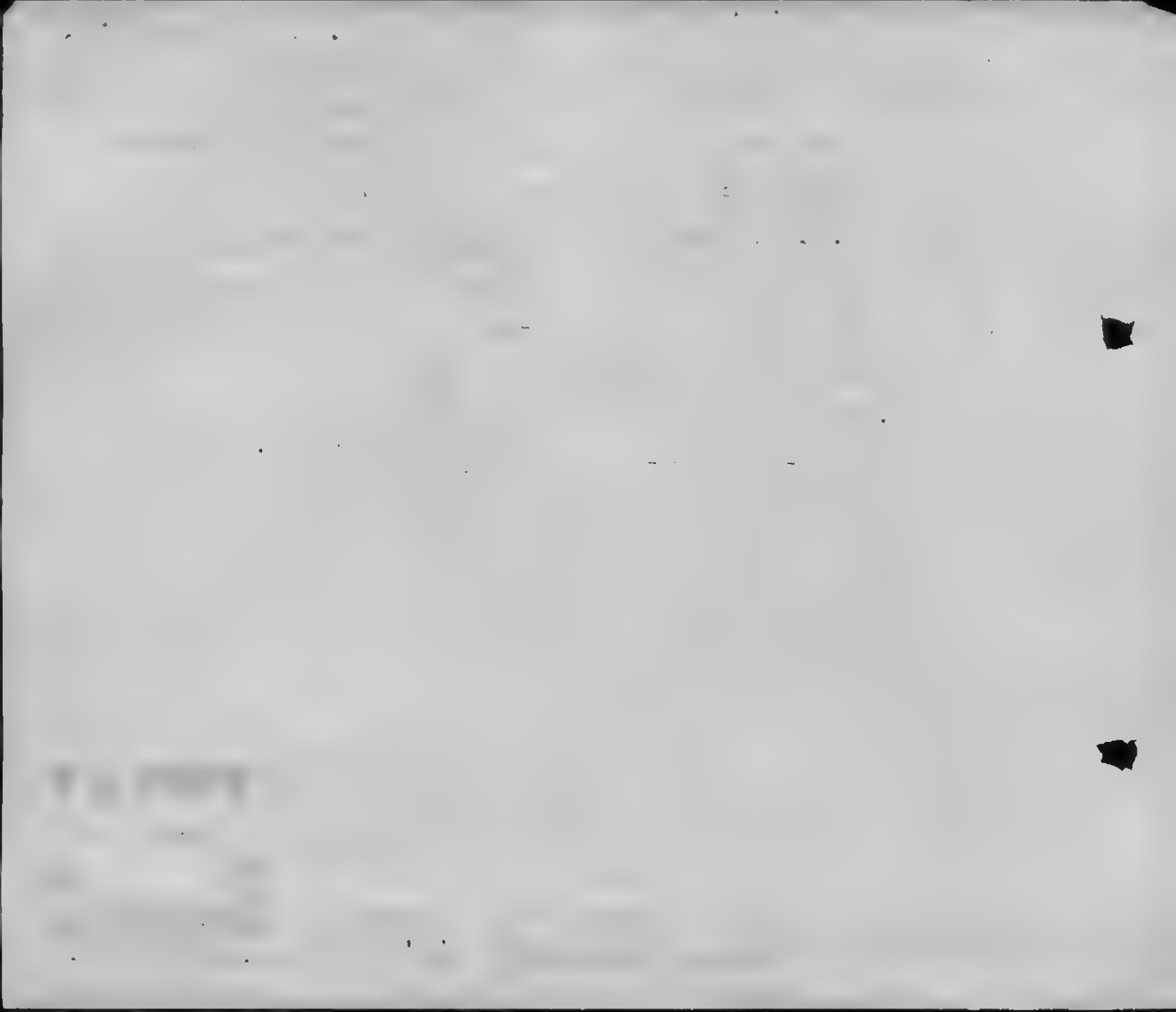
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Montgomery		MARYLAND		STATE Maryland COUNTY Montgomery			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Bethesda Rural		LENGTH OF STAY (in this place) 5 minutes		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Rockville			
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital				STREET ADDRESS (If rural, give location) 15 Paca Place			
3. NAME OF DECEASED: (First) Mary		(Middle) Lee		(Last) CARLIN		4. DATE OF DEATH (Month) (Day) (Year) January 17 19 56	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: 12-8-54	9. AGE last birthday: 1 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): None		10b. KIND OF BUSINESS OR INDUSTRY: None		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME: Michael J. CARLIN				14. MOTHER'S MAIDEN NAME: Leah SHINKLE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY No.: - -		17. INFORMANT & ADDRESS: Father Capt Michael J. CARLIN USAF Same as above			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: 4. Immediate cause (a) Pneumonia, interstitial DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							detained
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . SIGNATURE Frank J. Brochart M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/> DATE SIGNED 1-18-56							
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF 20 Jan 56		NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		LOCATION (City, town, or county) (State) Arlington, Virginia	
DATE REC'D BY LOCAL 18 Jan 1956		REGISTRAR'S SIGNATURE Mary E. Cassell		24. FUNERAL DIRECTOR R. A. Humphrey Funeral Home		ADDRESS 7557 Wisconsin Ave., Bethesda, Md.	



733

CERTIFICATE OF DEATH

Reg. Dist. No.

213

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>md</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	LENGTH OF STAY (in this place) <u>life</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rockville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>240 N. Washington St.</u>		STREET ADDRESS (If rural give location) <u>240 N. Washington St.</u>	
3. NAME OF DECEASED: (Type or Print) <u>Lucy</u> (First) (Middle) (Last) <u>Carroll</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>January 23 1956</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE <u>MARRIED</u> WIDOWED DIVORCED (Specify):	8. DATE OF BIRTH: <u>April 25 1874</u>
9. AGE last birthday: <u>81</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housekeeper</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>James W. Carroll</u>		14. MOTHER'S MAIDEN NAME: <u>Margaret E. Norris</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT'S ADDRESS: <u>Margaret Browne - Rockville, md</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>Anuria, Anoxia, Dehydration</u>		<u>2 weeks</u>
ANTECEDENT CAUSE (B) <u>Hypertension Arteriosclerosis</u>		<u>1948</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Chronic Nephritis without edema</u>		<u>1948</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Gall bladder or Hepatitis</u>		

19A. DATE OF OPERATION: <u>None</u>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 4, 1948, to Jan 23, 1956, that I last saw the deceased alive on Jan. 23 1956, and that death occurred at 5 A.M. from the causes and on the date stated above.

SIGNATURE Webster Sewell ADDRESS Rockville, Md. DATE SIGNED 1-25-56

23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>1-25-56</u>	NAME OF CEMETERY OR CREMATORY <u>Lincoln Park</u>	LOCATION (City, town, or county) (State) <u>Rockville, md</u>
DATE REC'D BY LOCAL REGISTRAR <u>1/25/56</u>	REGISTRAR'S SIGNATURE <u>Lamell H. Bingham</u>	24. FUNERAL DIRECTOR <u>Robert L. Sworden</u>	ADDRESS <u>Rockville, md</u>

MARGIN RESERVED FOR BINDING

BUREAU V. S.

IAN

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00719

761

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Montgomery</i>		MARYLAND		STATE <i>Virginia</i>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		83 X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		80 da		STREET ADDRESS (If rural give location)		Roanoke	
50 Nat'l Inst. Health		Darlington Rd.					
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<i>Charles Daniel Clark</i>				<i>Jan 2 1956</i>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<i>M</i>	<i>W</i>	<i>Single</i>	<i>9-21-37</i>	<i>18</i>	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?
<i>Student</i>					<i>Virginia</i>		<i>U.S</i>
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<i>Charles F. Clark</i>				<i>Louise Kessler</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:		
<i>No</i>			<i>---</i>		<i>Mother -</i>		
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE			(A) <i>Asphyxia</i>				<i>7 yr.</i>
ANTECEDENT CAUSE (B)			DUE TO <i>Epilepsy</i>				
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.			(C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
		<i>M.</i>					
22. I hereby certify that I attended the deceased from <i>10/24/55</i> , to <i>1/2</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>1/2</i> , 19 <i>56</i> , and that death occurred at <i>2: A.M.</i> from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<i>Henry N. Wagner Jr.</i>		<i>M.D. N.I.H.</i>		<i>Jan 2, 1956</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial - Transi</i>		<i>1/2/56</i>		<i>Fairview Cem.</i>		<i>Roanoke, Va.</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<i>1/3/56</i>		<i>Leslie M. Thompson</i>		<i>W.W. Chamber Co. 1400 Chapin St Wash</i>		<i>D.C.</i>	

BUREAU V. S.

JAN 5 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 216

762

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Montgomery	MARYLAND	STATE Virginia	COUNTY Alexandria
CITY (If outside corporate limits, write RURAL OR and give nearest town) Bethesda	LENGTH OF STAY (in this place) 11 days	CITY (If outside corporate limits, write RURAL and give nearest town) Alexandria	
HOSPITAL OR INSTITUTION OR STREET ADDRESS The Clinical Center Bethesda 14, Maryland		STREET ADDRESS (If rural give location) 301 East Glebe Road	

3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) Aurelia	(Middle) May	(Last) Clarke	(Month) January (Day) 25 (Year) 19 56
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: August 4, 1898
9. AGE last birthday: 57 yrs.		10. BIRTHPLACE (State or foreign country): District of Columbia	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME: Calvin Kennedy		14. MOTHER'S MAIDEN NAME: Mary Burgess	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. Not available	
17. INFORMANT & ADDRESS: The Medical Record, The Clinical Center			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) acute myelocytic leukemia		
ANTECEDENT CAUSE (B) 		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) 		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. 		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 14, 1956, to Jan. 25, 1956 that I last saw the deceased alive on Jan. 25, 1956, and that death occurred at 1:45 AM, from the causes and on the date stated above

SIGNATURE Robert J. Levine	ADDRESS M. D. The Clinical Center, NIH, Bethesda, Md.	DATE SIGNED 1/25/56
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Buried	DATE THEREOF 1-25-56	NAME OF CEMETERY OR CREMATORY Arlington 20
DATE REC'D BY LOCAL REGISTRAR 1-25-56	REGISTRAR'S SIGNATURE Bessie M. Thompson	24. FUNERAL DIRECTOR Cunningham F. Rome
		ADDRESS Alexandria

MARGIN RESERVED FOR BINDING

3 3 078000

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

763 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00721

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Montgomery</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Montgomery</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Bethesda</i>	LENGTH OF STAY (in this place) <i>12 day</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Rockville</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Suburban</i>		STREET ADDRESS (If rural give location) <i>St. #3</i>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <i>William</i>	(Middle) <i>Henry</i>	(Last) <i>Capeland</i>	DATE OF DEATH: <i>1-3-1956</i>
5. SEX: <i>male</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>W</i>	8. DATE OF BIRTH: <i>2-10-84</i>
9. AGE last birthday <i>71</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Cash</i>	
11. BIRTHPLACE (State or foreign country): <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME: <i>Groton Capeland</i>		14. MOTHER'S MAIDEN NAME: <i>Unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY No.	
17. INFORMANT & ADDRESS: <i>Lucille Capeland - daughter</i>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>Cerebral vascular accident</i>			<i>4 day</i>
ANTECEDENT CAUSE (B) <i>Arterio-sclerosis</i>			<i>years -</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>1/1</i> , 1956, to <i>1/3</i> , 1956, that I last saw the deceased alive on <i>1/3</i> , 1956, and that death occurred at <i>7:15 P.M.</i> , from the causes and on the date stated above.			
SIGNATURE <i>Richard S. Norton</i>		ADDRESS <i>Bethesda Md</i>	
DATE SIGNED <i>1/3/56</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>1/7/56</i>	
NAME OF CEMETERY OR CREMATORY <i>Brooke Grove</i>		LOCATION (City, town, or county) (State) <i>Laytonsville, Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>1/9/56</i>		REGISTRAR'S SIGNATURE <i>Anna M. Thompson</i>	
FUNERAL DIRECTOR <i>Robert L. Snowden</i>		ADDRESS <i>Rockville Md</i>	

LIBRARY V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Montgomery		MARYLAND		STATE District of Columbia		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington, D.C.	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda Rural		LENGTH OF STAY (in this place) 25 days		STREET ADDRESS (If rural give location) 1400 Fairmont Street, N.W.			
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital							
3. NAME OF DECEASED: (First) William (Middle) Eugene (Last) CORDELL				4. DATE (Month) (Day) (Year) OF DEATH: January 3 1956			
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married		8. DATE OF BIRTH: 7-15-94	
9. AGE last birthday 61 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if floor Refinisher) Floor Refinisher		10b. KIND OF BUSINESS OR INDUSTRY: Maintenance		11. BIRTHPLACE (State or foreign country): Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? US				13. FATHER'S NAME: William CORDELL			
14. MOTHER'S MAIDEN NAME: Lucy RYAN				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give year or dates of service) WW I			
16. SOCIAL SECURITY NO. Unknown				17. INFORMANT & ADDRESS: wife Mrs. Grace P. CORDELL Same as above			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) BRONCHOPNEUMONIA						1 week	
ANTECEDENT CAUSE (B) BRONCHOSTENOSIS, left main stem						8 mos. +	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) BRONCHOGENIC CARCINOMA WITH METASTASES						8 mos. +	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. ATHEROSCLEROSIS, WIDESPREAD						20+ yrs.	
19a. DATE OF OPERATION: 2		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21c. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 8 Dec... , 19 55 to 3 Jan , 19 56 that I last saw the deceased alive on 3 Jan , 19 56 , and that death occurred at ... M, from the causes and on the date stated above.							
SIGNATURE OF REGISTRAR W. B. INGRAM CDR, MC, USN U. S. Naval Hospital, NNMC, Bethesda, Maryland							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 6 Jan 1956		NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		LOCATION (City, town, or county) (State) Arlington, Virginia	
DATE REC'D BY LOCAL REGISTRAR 3 Jan 1956		REGISTRAR'S SIGNATURE May C. Crumley		24. FUNERAL DIRECTOR S. H. HINES Funeral Home		ADDRESS 2901 14th Street, N.W. Washington, D.C.	

MARGIN RESERVED FOR BINDING

U.S. AIR FORCE

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00723

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Montgomery		MARYLAND		STATE Kentucky		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda Rural		LENGTH OF STAY (in this place) 31 days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Garrison			
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last) Christinia Agnes COTTON				4. DATE (Month) (Day) (Year) OF DEATH: January 29 1956			
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 4-12-16	9. AGE last birthday 39 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife		10B. KIND OF BUSINESS OR INDUSTRY: Housewife		11. BIRTHPLACE (State or foreign country): New Hampshire		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME: Harold CLOUGH				14. MOTHER'S MAIDEN NAME: Harriett BILERUCK			
15. HAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT'S ADDRESS: Husband Carl W. COTTON Same as above			
15. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE 191. Pulmonary Edema & Cardiac Failure				approx.			
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				20 days.			
(A) DUE TO							
(B) DUE TO							
(C) metastatic carcinoma of pleura							
(C) mediastinum & diaphragm							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				Intestinal Obstruction, recurrent			
19A. DATE OF OPERATION: 5 January 1956		19B. MAJOR FINDINGS OF OPERATION Carcinomatous Elemental Mass & Intest. Obstruction		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 29 Dec., 1955. , to 29 Jan., 1956 , that I last saw the deceased alive on 29 Jan., 1956 , and that death occurred at 10:50A. from the causes and on the date stated above.							
SIGNATURE B. C. JOHNSON LT, MC, USN U. S. Naval Hospital, NNMC, Bethesda, Maryland		ADDRESS		DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 2 Feb 1956		NAME OF CEMETERY OR CREMATORY Warren Cemetery		LOCATION (City, town, or county) (State) Garrison, Kentucky	
DATE REC'D BY LOCAL REGISTRAR 30 Jan 1956		REGISTRAR'S SIGNATURE <i>Harry E. Gassell</i>		24. FUNERAL DIRECTOR R. A. Pumphrey Funeral Home		ADDRESS 7557 Wisconsin Ave., Bethesda, Md.	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU & S.

766

CERTIFICATE OF DEATH

Reg. Dist. No. 217.....

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Carroll</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dinwiddie</u>	LENGTH OF STAY (in this place) <u>1 yr. 7 mo.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Airy</u>	OR TOWN <u>Mt. Airy</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sharon Chronic Hosp.</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) <u>Leannah</u> (Middle) <u>B.</u> (Last) <u>Crockett</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan-4</u> 19 <u>56</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W-</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>July 9, 1863</u>
9. AGE last birthday: <u>92</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Kemptown Md</u>	
11. BIRTHPLACE (State or foreign country): <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Greenberry Baker</u>		14. MOTHER'S MAIDEN NAME: <u>Hepzibah Brandenburg</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INTERMENT & ADDRESS: <u>Sharon Chronic Hosp. records</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Cardiac Exhaustion</u>			<u>2 yrs.</u>
ANTECEDENT CAUSE (S) (B) <u>Debility, Senility + gen.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) <u>For advanced Art. Sclerosis</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5-31-1954</u> to <u>1-4-1956</u> , that I last saw the deceased alive on <u>1-4-</u> 19 <u>56</u> , and that death occurred at <u>2:30 P</u> M, from the causes and on the date stated above.			
SIGNATURE <u>John B. Ziegler</u>		DATE SIGNED <u>1-4-56</u>	
ADDRESS <u>M. D. Alvey, Md</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 7, 1956</u>	
NAME OF CEMETERY OR CREMATORY <u>Providence</u>		LOCATION (City, town, or county) (State) <u>Kemptown, Fred. Co. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-6-56</u>		REGISTRAR'S SIGNATURE <u>Bertinda B. Lawler</u>	
24. FUNERAL DIRECTOR <u>Olin L. Molesworth</u>		ADDRESS <u>Damascus, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

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767

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Montgomery	MARYLAND	STATE Ohio	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) Bethesda Rural	LENGTH OF STAY (in this place) 4mo 2 days	CITY (If outside corporate limits, write RURAL and give nearest town) Columbiana	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital		STREET ADDRESS (If rural give location) Elkton Road	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) Jervace	(Middle) Letha	(Last) CROUSE	(Month) January (Day) 17 (Year) 1956
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: 2-12-05
9. AGE last birthday 50 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Navy Nurse		10B. KIND OF BUSINESS OR INDUSTRY: Navy	
11. BIRTHPLACE (State or foreign country): Ohio		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME: Elmer H. CROUSE		14. MOTHER'S MAIDEN NAME: Nettie REESH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Yes WW II & Korea		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT'S ADDRESS: Brother Mr. Andrew CROUSE		Same as above	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
192X IMMEDIATE CAUSE	(A) Pulmonary edema	? 2 days
ANTECEDENT CAUSE (S)	(B) Metastatic melanoma	1 year
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(C) Melanoma, left eye	2 years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from 15 Sept, 1955 , to 17 Jan, 1956 , that I last saw the deceased alive on 17 Jan, 1956 , and that death occurred at 7:50 PM , from the causes and on the date stated above.				
SIGNATURE F. W. MYER		ADDRESS U. S. Naval Hospital, NMMC, Bethesda, Maryland		DATE SIGNED
23. BURIAL, CREMATION, REBURNAL (SPECIFY) Burial		DATE THEREOF 21 Jan 1956		NAME OF CEMETERY OR CREMATORY Columbiana Cemetery
				LOCATION (City, town, or county) (State) Columbiana, Ohio
DATE REC'D BY LOCAL 18 JAN 1956		REGISTRAR'S SIGNATURE Mary E. Cassell		R4. FUNERAL DIRECTOR R. A. Humphrey
				ADDRESS 7557 Wisconsin Avem, Bethesda, Md.

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00726

Items 8,9,10 film G199 7-10-56 **CERTIFICATE OF DEATH**

Reg. Dist. No. 216

1. PLACE OF DEATH: Kenwood				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Montgomery		MARYLAND		STATE md		COUNTY Montgomery	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Kenwood		LENGTH OF STAY (in this place) 25 yrs		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Kenwood			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 5331 Chamberlin Ave Kenwood, Md				STREET ADDRESS (If rural give location) 5331 Chamberlin Ave			
3. NAME OF DECEASED. (First) (Middle) (Last) Judson Thomas Cull Jr.				4. DATE (Month) (Day) (Year) OF DEATH: 1 - 29 1956			
5. SEX: Male		6. COLOR OR RACE: white		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Single		8. DATE OF BIRTH: 1882 10 - 16 - 1883	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): lawyer		10B. KIND OF BUSINESS OR INDUSTRY: law		9. AGE last birthday: 73 yrs		11. BIRTHPLACE (State or foreign country): Washington, DC.	
13. FATHER'S NAME: Judson Thomas Cull				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): NO (If Yes, give war or dates of service) None				14. MOTHER'S MAIDEN NAME: Mary M Lanohana		17. INFORMANT & ADDRESS: 5331 Chamberlin Ave Kenwood, Md.	
16. SOCIAL SECURITY NO. None				18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
446X IMMEDIATE CAUSE (A) Uremic Coma				8 hours			
ANTECEDENT CAUSE (B) Chronic Interstitial Nephritis							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Generalized Atherosclerosis							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Myocardial infarction							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov. 12, 1955 , to Jan 24, 1956 that I last saw the deceased alive on Jan. 28 - 1956 , and that death occurred at 1:00 P.M. , from the causes and on the date stated above.							
SIGNATURE Francis J. Spahr				ADDRESS M. D. 3328 O-St. N.W. Wash. D.C.		DATE SIGNED 1-29-56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		DATE THEREOF 1-30-56		NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		LOCATION (City, town, or county) (State) Suitland, Maryland	
DATE REC'D BY LOCAL REGISTRAR 1-31-56		REGISTRAR'S SIGNATURE Bessie M. Thompson		FUNERAL DIRECTOR'S SIGNATURE Robert H. Humphrey		ADDRESS Bethesda, Md.	

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

769

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00727

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED STATE _____ COUNTY _____			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>			
TOWN _____				TOWN _____			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>				STREET ADDRESS (If rural, give location) <u>3120 Silver St. N.W.</u>			
3. NAME OF DECEASED (Type or Print) <u>William</u> (First) <u>Clawson</u> (Middle) <u>Cunningham</u> (Last)				4. DATE OF DEATH (Month) <u>1</u> (Day) <u>15</u> (Year) <u>1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>9-16-88</u>	
9. AGE last birthday <u>67</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>sales clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>		11. BIRTHPLACE (State or foreign country) <u>Texas</u>	
13. FATHER'S NAME <u>James C. Cunningham</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year, of date of service) <u>yes</u> <u>W.B.T.</u>				14. MOTHER'S MAIDEN NAME <u>Henrietta Manlove</u>			
16. SOCIAL SECURITY No. <u>211-21-1111</u>				17. INFORMANT AND ADDRESS <u>Miss Cunningham (wife)</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Congestive Heart Failure</u>						<u>15 mos.</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last							
(b) <u>Healed Bacterial Endocarditis</u>						<u>17 mos.</u>	
(c) <u>Rheumatic Heart Disease</u>						<u>years</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY)	
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 5</u> , 19 <u>54</u> to <u>Jan 15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 15</u> , 19 <u>56</u> , and that death occurred at <u>5:10 p.m.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Robert D. [Signature]</u>				Degree or title <u>M.D.</u>		ADDRESS <u>5516 Nebraska Ave D.C. 1-15-56</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>buried</u>		DATE THEREOF <u>1-18-56</u>		NAME OF CEMETERY OR CREMATORY <u>Washington, D.C.</u>		LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
DATE REC'D BY LOCAL REG. <u>1-16-56</u>		REGISTRAR'S SIGNATURE <u>W. M. Thompson</u>		24. FUNERAL DIRECTOR <u>4812 1st St. N.W. Wash. D.C.</u>			

110000

770

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

COUNTY Montgomery

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BethesdaLENGTH OF STAY (in this place) 99 daysHOSPITAL OR INSTITUTION OR STREET ADDRESS The Clinical Center Bethesda, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE West Virginia COUNTY --CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Dothan, West VirginiaSTREET ADDRESS (If rural give location) Box 150

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

Theodore Roosevelt Daniels

4. DATE (Month) (Day) (Year)

OF DEATH: Jan. 18, 1956

5. SEX:

Male

6. COLOR OR RACE:

White7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH:

17 July 1900

9. AGE last birthday

55 yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Timberman10B. KIND OF BUSINESS OR INDUSTRY: Lumber

11. BIRTHPLACE (State or foreign country):

West Virginia

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME:

William H. Daniels

14. MOTHER'S MAIDEN NAME:

Rebecca Daniels15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No

16. SOCIAL SECURITY NO.

232-28-3094

17. INFORMANT & ADDRESS:

The Medical Record, The Clinical Center

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE

(A)

DUE TO Squamous cell Carcinoma Left Chest Wall + Apella

ANTECEDENT CAUSE (B)

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Esophageal Ulcerations

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

1-13-56

19B. MAJOR FINDINGS OF OPERATION:

Squamous cell Carcinoma Left Chest Wall + Apella

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While ☐ Not while ☐ at work ☐ at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 11 1955, to Jan. 18, 1956, that I last saw the deceasedalive on Jan. 18, 1956, and that death occurred at 7:10AM, from the causes and on the date stated above.

SIGNATURE

Ross M. Miller, Jr.

M. D.

N.I.H. - Bethesda Md.

DATE SIGNED

1-18-56

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial-transit

DATE THEREOF

1/20/56

NAME OF CEMETERY OR CREMATORY

Peters Cemetery

LOCATION (City, town, or county)

Fayette Co.

(State)

W. Virginia

DATE REC'D BY LOCAL REGISTRAR

1-31-56

REGISTRAR'S SIGNATURE

Bessie M. Thompson

24. FUNERAL DIRECTOR

Robert A. Humphrey

ADDRESS

Bethesda, Md.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLS

CERTIFICATE OF DEATH

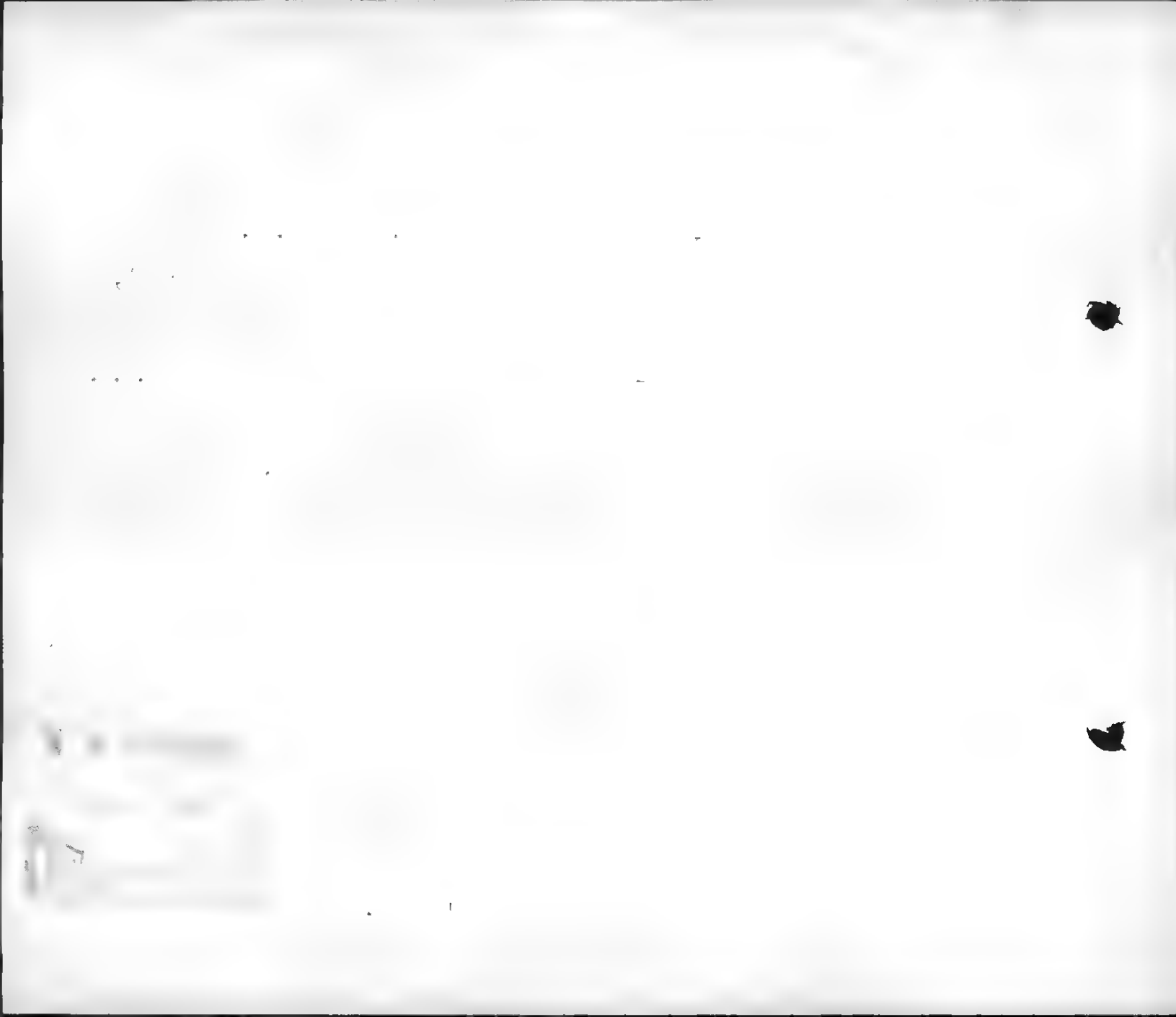
Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Montgomery	MARYLAND	District of Columbia	
CITY (If outside corporate limits, write RURAL or and give nearest town)	LENGTH OF STAY (in this place)	STATE COUNTY	
Bethesda	14 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS The Clinical Center National Inst. of Health		STREET ADDRESS (If rural give location) 1845 M. Street N. E. Apt 2	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year) OF DEATH:	
(First) Dianna	(Middle) Telcia	(Last) Dean January 24, 19 56	
5. SEX: Female	6. COLOR OR RACE: Negro	7. SINGLE. MARRIED. WIDOWED, DIVORCED. (Specify): Single	8. DATE OF BIRTH: April 10, 1955
9. AGE last birthday: 9 yrs. 9 months 14 days		10. AGE last birthday: 9 yrs. 9 months 14 days	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child		10B. KIND OF BUSINESS OR INDUSTRY: ---	
11. BIRTHPLACE (State or foreign country): New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Berlin Dean		14. MOTHER'S MAIDEN NAME: Delores Carter	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no		16. SOCIAL SECURITY NO. None	
17. INFORMANT & ADDRESS: The Medical Record, The Clinical Center			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) 757.4 VENTRICULAR FIBRILLATION			
ANTECEDENT CAUSE (B) CARDIAC SURGERY			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) ANOMALOUS LEFT CORONARY ARTERY			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 1/24/56		19B. MAJOR FINDINGS OF OPERATION: LEFT VENTRICULAR INFARCTION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan 10 , 1956, to Jan 24 , 1956, that I last saw the deceased alive on Jan 24 , 1956, and that death occurred at 6:00 PM , from the causes and on the date stated above.			
SIGNATURE Robert A. Salerno		DATE SIGNED 1/25/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 1/27/56	
NAME OF CEMETERY OR CREMATORY Burlington Natl. Cemetery		LOCATION (City, town, or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR Robert G. McQuire		ADDRESS 1820-4 48th NW	

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



772

CERTIFICATE OF DEATH

Reg. Dist. No. 216...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>Bethesda</u>		<u>4 days</u>		TOWN <u>Rockville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>				STREET ADDRESS (If rural give location) <u>1625 Lewis Avenue</u>			
3. NAME OF DECEASED: (First) <u>John</u> (Middle) <u>Joseph</u> (Last) <u>DeLarco</u>				4. DATE OF DEATH: (Month) <u>Jan.</u> (Day) <u>31</u> (Year) <u>1956</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>W</u>		8. DATE OF BIRTH: <u>March 21-1892</u>	
9. AGE last birthday: <u>63</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Barber</u>		11. BIRTHPLACE (State or foreign country): <u>Philadelphia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>John Lewis E. Larco</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>1625 Lewis Ave</u> <u>Jacqueline Fabler daughter</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE <u>470.1</u>				<u>5 days</u>			
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>confluent bronchopneumonia</u>							
(B) <u>massive myocardial infarct</u>				<u>old 8 2 mm recent 1 day</u>			
(C) <u>coronary artery disease</u>				<u>2 years</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/29</u> , 1956 to <u>1/31</u> , 1956 that I last saw the deceased alive on <u>1/31</u> , 1956, and that death occurred at <u>8:05</u> P.M., from the causes and on the date stated above.							
SIGNATURE <u>Charles J. Sauer</u>				ADDRESS <u>M.D. 4868 Pothier Rd. Bethesda</u>		DATE SIGNED <u>2/1/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2-3-56</u>		<u>Rockville Union</u>		<u>Rockville Montg. Co. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2/4/56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>		ADDRESS <u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W. A. GUTHRIE

772

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Dist. of Col.</u> COUNTY			
CITY (If outside corporate limits, write RURAL, OR and give nearest town) <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>22 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Washington, D.C.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Besmor Sanitarium</u>				STREET ADDRESS (If rural give location) <u>3620-16th St. NW.</u>			
3. NAME OF DECEASED: (First) <u>Edna</u> (Middle) <u>Holland</u> (Last) <u>Donnelly</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>1</u> <u>8</u> <u>1956</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Caucasian</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>9 May 1885</u>	9. AGE last birthday: <u>70</u> yrs.	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS.: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>—</u>		11. BIRTHPLACE (State or foreign country): <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Richard Bowie Holland</u>				14. MOTHER'S MAIDEN NAME: <u>Ada Drummond</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-16-6806</u>		17. INFORMANT & ADDRESS: <u>Willis Holland Brown, 4302 Everett St Kensington, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Carcinomatosis, generalized</u>						<u>4+ mos.</u>	
ANTECEDENT CAUSE (B) <u>Carcinoma of colon</u>						<u>6+ mos.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>—</u>		19B. MAJOR FINDINGS OF OPERATION: <u>—</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>—</u> M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR? <u>—</u>			
22. I hereby certify that I attended the deceased from <u>—</u> , 1952 to <u>Jan. 8th</u> , 1956, that I last saw the deceased alive on <u>Jan. 7</u> , 1956, and that death occurred at <u>1:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Henry D. Ecker</u>		M.D. <u>917-20th St. N.W.</u>		DATE SIGNED <u>1/8/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-12-56</u>		NAME OF CEMETERY OR CREMATORY <u>Rockville Union</u>		LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/12/56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		FUNERAL DIRECTOR <u>Robert G. Humphrey</u>		ADDRESS <u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.



774
CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>D. C.</u>	COUNTY <u>--</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Bethesda</u>	LENGTH OF STAY (in this place) <u>13 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Washington, D. C.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center Bethesda, Maryland</u>		STREET ADDRESS (If rural give location) <u>910 G Street, S. W.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Sylvia Louise Driver</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan. 9, 1956</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>30 Oct. 1924</u>
9. AGE last birthday <u>31</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country): <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Walter Kelly</u>		14. MOTHER'S MAIDEN NAME: <u>Blanche (unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>Not available</u>	
17. INFORMANT & ADDRESS: <u>The Medical Record, The Clinical Center</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Gastrointestinal + Pulmonary Hemorrhage</u>			<u>1 wk.</u>
ANTECEDENT CAUSE (B) <u>Thrombocytopenia</u>			<u>2 wks.</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Acute Lymphocytic Leukemia</u>			<u>7 mos.</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>None</u>			
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Dec. 27, 1955, to Jan. 9, 1956 that I last saw the deceased alive on Jan. 9, 1956, and that death occurred at 6:24 A.M. from the causes and on the date stated above.			
SIGNATURE <u>Thomas L. Gorsuch, M.D.</u>		DATE SIGNED <u>1/9/56</u>	
ADDRESS <u>The Clinical Center, NIH, Bethesda, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY): <u>Burial</u>		DATE THEREOF <u>1-14-56</u>	
NAME OF CEMETERY OR CREMATION <u>Lincoln Mem. Cem.</u>		LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/10/56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	
24. FUNERAL DIRECTOR <u>Griffin Funeral Home 350 E. L. St. N.W.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3 1 0 5 2 0 0 5

(continued)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 00733 214

1. PLACE OF DEATH COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> TOWN <u>Silver Spring</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10151 Sutherland Road</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring Md.</u> TOWN <u>Silver Spring</u> STREET ADDRESS (If rural give location) <u>10151 Sutherland Road</u>	
3. NAME OF DECEASED (Type or Print) <u>SUSIE WINIFRED ECKLOFF</u>		4. DATE OF DEATH (Month) <u>JANUARY</u> (Day) <u>18</u> (Year) <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 20 1883</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	9. AGE last birthday <u>72</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>CHARLES A. CAHO</u>		14. MOTHER'S MAIDEN NAME <u>LOTTIE HEISIE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>no</u>	
17. INFORMANT <u>Granddaughter Mary E. Munster</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <u>(a) Acute left ventricular failure</u>		<u>3 days</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
<u>(b) Arteriosclerotic Heart Disease</u>		<u>several yrs.</u>
<u>(c) Cerebral hemorrhage (1949) - right</u>		<u>6 1/2 yrs.</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Colostomy (1949)</u>		
19a. DATE OF OPERATION <u>none</u>	19b. MAJOR FINDINGS OF OPERATION <u>—</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>no</u>	PLACE (Home, farm, factory, street, office hldg., etc.) <u>—</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>none</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>—</u>

22. I hereby certify that I attended the deceased from Sept., 1954, to January, 1956, that I last saw the deceased alive on January 17, 1956, and that death occurred at 6:30 p.m., from the causes and on the date stated above.

SIGNATURE Belden R. Klap, MD ADDRESS 11502 Grandview Ave. S.S. Md. DATE SIGNED 1/18/56

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE THEREOF 1-21-56 NAME OF CEMETERY OR CREMATORY Thomson Cemetery LOCATION (City, town, or county) Washington D. C. (State)

DATE REC'D BY LOCAL REG. 1-20-56 REGISTRAR'S SIGNATURE Frances Potter 24. FUNERAL DIRECTOR Martin W. Hyman & Co ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

BUREAU V. S.

RECEIVED
JAN 11 1901

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00734

Reg. Dist.

No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write name of nearest town) <u>Silver Spring</u>		LENGTH OF STAY (in this place) <u>30 days</u>		CITY (If outside corporate limits write name of nearest town) <u>Silver Spring</u>		<u>57</u>	
TOWN <u>Silver Spring</u>				TOWN <u>Silver Spring</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hoof</u>				STREET ADDRESS (If rural, give location) <u>1806 Sherwood Rd</u>			
3. NAME OF DECEASED: (First) <u>Marion</u> (Middle) <u>Eleanor</u> (Last) <u>Emerick</u>				4. DATE OF DEATH: (Month) <u>1</u> (Day) <u>19</u> (Year) <u>56</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>12/31/66</u>	
				9. AGE last birthday: <u>89</u> yrs.		10. IF UNDER 1 YEAR (Months) <u></u> (Days) <u></u> (Hours) <u></u> (Min.) <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Homemaker</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>own home</u>		11. BIRTHPLACE (State or foreign country): <u>Lewistown, Pennsylvania</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John Emerick</u>				14. MOTHER'S MAIDEN NAME: <u>Rosanna Eleanor Rider</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>none</u>		17. INFORMANT & ADDRESS: <u>Mrs. Ruth E. Reppert, 1806 Sherwood Rd. Silver Spring, Maryland</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
<u>110.3</u> Immediate cause (a) <u>Cerebral hemorrhage</u> DUE TO						<u>33 day</u>	
Antecedent cause(s) (b) <u>Compressed fracture of skull (at occipital)</u> DUE TO							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: <u>Fracture Rt. hip</u>							
19a. DATE OF OPERATION: <u>1-19-56</u>		19b. MAJOR FINDING OF OPERATION: <u>Fracture Rt. hip</u>					
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: <u>home</u>		21c. (City or town) (County) (State) <u>Silver Spring Montg md</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>12-16-55</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fell down basement steps</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
SIGNATURE <u>Frank J. Broschant</u>		M. D. <u>Bessie M. Loomis</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>1-20-56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Greenwood Cemetery</u>		DATE THEREOF <u>1/23/56</u>		LOCATION (City, town, or county) (State) <u>Briella, New Jersey</u>			
DATE REC'D BY LOCAL REG. <u>1-20-56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Loomis</u>		24. FUNERAL DIRECTOR <u>Warren L. Humphrey</u>		ADDRESS <u>Silver Spring, Md.</u>	



00735

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Montgomery</i>	MARYLAND	STATE <i>D. C.</i>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	OR
X TOWN <i>Bethesda</i>		TOWN <i>Washington</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Suburban Hospital</i>		STREET ADDRESS (If rural give location) <i>431 Kennedy N.W.</i>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<i>Baby Bay Evans</i>		<i>1 16 1956</i>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:
<i>Male</i>	<i>White</i>	<i>---</i>	<i>1-16-56</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):
<i>Infant</i>		<i>none</i>	<i>Maryland-Bethesda</i>
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<i>James W. Evans</i>		<i>Doris L. Evans</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS:
<i>no</i>		<i>none</i>	<i>Father-James W. Evans 431 Kennedy N.W. Wash DC</i>

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE	(A) DUE TO	<i>1 day</i>
ANTECEDENT CAUSE (S)	(B) DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
<i>Hypoxia - prolapsed cord</i>	

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
<i>2</i>		

21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *16 JAN, 1956* to *16 JAN, 1956* that I last saw the deceased alive on *16 JAN, 1956*, and that death occurred at *5:45 PM*, from the causes and on the date stated above.

SIGNATURE <i>J. W. Pearlman</i>	DATE SIGNED <i>16 JAN 1956</i>
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	NAME OF CEMETERY OR CREMATORY
<i>Burial</i>	<i>Arlington Nat. Cem</i>
DATE THEREOF <i>1-19-56</i>	LOCATION (City, town, or county) (State)
	<i>Arlington Virginia</i>

DATE REC'D BY LOCAL REGISTRAR <i>1/20/56</i>	REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i>	24. FUNERAL DIRECTOR ADDRESS <i>Bethesda, Md.</i>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

778

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00736

CERTIFICATE OF DEATH

Reg. Dist. No. 2.17.....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<u>Rural Brookville Md</u>		<u>3 yrs</u>		<u>Brookville Md</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Rural Brookville Md</u>				<u>Rural</u>			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(First)		(Middle)		(Last) (Everhart)			
<u>Clara</u>		<u>Jane</u>		<u>Everhart</u>			
(Type or Print)				OF DEATH:			
<u>5</u>		<u>6</u>		<u>1</u>		<u>2</u>	
SEX:		COLOR OR RACE		7. SINGLE MARRIED, WIDOWED, DIVORCED (Specify):		8. DATE OF BIRTH.	
<u>F</u>		<u>W.</u>		<u>Married</u>		<u>Oct 18 - 1875</u>	
						<u>80</u> yrs.	
						<u>9</u> Months <u>14</u> Days <u>14</u> Hours <u>14</u> Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>None</u>				<u>None</u>		<u>Maryland</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Jos. McCrossin</u>				<u>Louisa Miller</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>no</u>				<u>none</u>		<u>A. S. Everhart, 23 Has...</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A)						<u>years</u>	
ANTECEDENT CAUSE (B)						<u>34 hrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
<u>Arteriosclerosis</u>							
<u>Cerebral Hemorrhage</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						<u>Diabetes</u>	
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<u>None</u>				<u>None</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			
				21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
				21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/24, 1955</u> , to <u>1/1, 1956</u> that I last saw the deceased alive on <u>1/1</u> , 19 <u>56</u> , and that death occurred at <u>11:55 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				DATE SIGNED <u>1/2/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				NAME OF CEMETERY OR CREMATORY			
<u>Burial</u>				<u>Darnestown PresbyCh.Cem</u>			
DATE REC'D BY LOCAL REGISTRAR <u>1-6-56</u>				24. FUNERAL DIRECTOR ADDRESS <u>Bethesda, Md.</u>			

U. S. DEPARTMENT OF AGRICULTURE

OFFICE OF THE
SECRETARY

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00737
713 CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Okema Park</u> TOWN <u>Okema Park</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash Sanatorium & Hospital</u>	MARYLAND LENGTH OF STAY (in this place) <u>22 days</u>	STATE <u>—</u> COUNTY <u>—</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>District of Columbia</u> STREET ADDRESS (If rural give location) <u>215 Cedar Street N.W.</u>	
3. NAME OF DECEASED: (Type or Print) <u>Elvira Mildred Farrell</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>1 - 2 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE: <u>Caucasian</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED: <u>Widow</u>	8. DATE OF BIRTH: <u>10 - 18 - 85</u>
9. AGE last birthday <u>70</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>—</u>	11. BIRTHPLACE (State or foreign country): <u>Iowa</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME: <u>Charles Curtiss</u>	
14. MOTHER'S MAIDEN NAME: <u>Rebecca Maddox</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service) <u>—</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS: <u>Hospital Records</u>	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE <u>Encephalomalacia</u>		<u>10 days</u>	
(B) ANTECEDENT CAUSE (S) <u>Thrombosis Left Cerebral Artery</u>		<u>10 days</u>	
(C) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST <u>Cerebral Arteriosclerosis</u>		<u>? years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetes Mellitus</u>		<u>10 1/2 years</u>	
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) M.	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May 1955</u> , to <u>Jan 2, 1956</u> , that I last saw the deceased alive on <u>Jan 2, 1956</u> , and that death occurred at <u>11:15</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Robert A. Hare</u>		ADDRESS <u>M.D. Takoma Park Md</u> DATE SIGNED <u>1/3/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan 5, 1956</u>	
NAME OF CEMETERY OR CREMATORY <u>National Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Falls Church, VA</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Jan 4 1956</u>		REGISTRAR'S SIGNATURE <u>John D. Bell</u>	
FUNERAL DIRECTOR <u>James Williams</u>		ADDRESS <u>254 Carroll St. N.W. Takoma Park, D.C.</u>	

U. S. DEPARTMENT

1915

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

773

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00738

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> TOWN <u>Bethesda</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MD.</u> COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> OR TOWN <u>Bethesda</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>				STREET ADDRESS (If rural give location) <u>8510 Garfield St.</u>			
3. NAME OF DECEASED: (Type or Print) <u>Prince George Finlayson</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>JAN. 9 1956</u>			
5. SEX: <u>m</u>	6. COLOR OR RACE: <u>w</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH: <u>April 8 1904</u>	9. AGE last birthday: <u>51</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Administrative Maritime Service</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Boston, MASS.</u>		11. BIRTHPLACE (State or foreign country): <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME: <u>John Smith Finlayson</u>			
14. MOTHER'S MAIDEN NAME: <u>Isabel Faulkner Berry</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT & ADDRESS: <u>8510 Garfield St. Sarah Park Finlayson-Bethesda, Md.</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Confluent Bronchopneumonia</u>							<u>? days</u>
ANTECEDENT CAUSE (B) DUE TO <u>Massive Myocardial Infarct, old</u>							<u>8 years</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Coronary Arteriosclerosis Advanced</u>							<u>? years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Parkinsonism</u>							<u>? years</u>
19A. DATE OF OPERATION: <u>2</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 1956</u> , to <u>Jan. 1956</u> , that I last saw the deceased alive on <u>Jan. 1956</u> , and that death occurred at <u>1:51 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS <u>M. D. Suburban Hosp. Bethesda, Md.</u>		DATE SIGNED <u>9 Jan 56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/12/56</u>		NAME OF CEMETERY OR CREMATORY <u>St. Lincoln</u>		LOCATION (City, town, or county) (State) <u>Prince George's Co., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/10/56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Wm. H. Niles Co.</u>		ADDRESS <u>2901 N. 2nd St. Wash. DC 20001</u>	

BOOK NO. 8

W. H. B. 11

CERTIFICATE OF DEATH

Reg. Dist. No. 216

780

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write and give nearest town) <u>Bethesda</u>	RURAL LENGTH OF STAY (in this place) <u>8 days</u>	CITY (If outside corporate limits, write and give nearest town) <u>Silver Spring</u>	TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hosp.</u>		STREET ADDRESS (If rural give location) <u>12029 Dalewood Drive</u>	
3. NAME OF DECEASED: (Type or Print) <u>Raymond Fishburne Fleming</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan. 28, 1956</u>	
5. SEX: <u>Male</u>	6. COLOR (OR RACE): <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>April 3, 1899</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Mechanic</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Frank J. Fleming</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Elizabeth Ball</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Wife - Hazel Fleming above</u>			

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) <u>Acute intestinal hemorrhage</u>		<u>2 days</u>
ANTECEDENT CAUSE (B) <u>Perforating peptic ulcer, stomach, free peritoneal effusion, Rt. extremity, thrombosed Rt. iliac artery</u>		<u>2 days</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		<u>4-5 days</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION: <u>2</u>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from , 19....., to , 19....., that I last saw the deceased alive on , 19....., and that death occurred at 9:45 AM, from the causes and on the date stated above.

SIGNATURE <u>Charles Savaris</u> M.D.		ADDRESS <u>4860 Battery Rd</u>	DATE SIGNED <u>1/29/56</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>2/1/56</u>	NAME OF CEMETERY OR CREMATORY <u>Arlington</u>	LOCATION (City, town, or county) (State) <u>Arlington Va</u>
DATE REC'D BY LOCAL REGISTRAR <u>1-30-56</u>	REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	24. FUNERAL DIRECTOR <u>The S. H. Jones Co.</u>	ADDRESS <u>2901-146 St NW</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

U. S. DEPARTMENT OF AGRICULTURE



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

730

00740
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 213

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Rockville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Rockville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>530 W. Montg. Ave.</u>				STREET ADDRESS (If rural, give location) <u>530 W. Montg. Ave.</u>			
3. NAME OF DECEASED: (Type or Print) <u>WILLIAM A. FLING</u>				4. DATE OF DEATH <u>Jan. 8, 1956</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH: <u>May 28, 1892</u>	
9. AGE last birthday: <u>63</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Laundrey-Self Emp.</u>		11. BIRTHPLACE (State or foreign country): <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME: <u>Wm. F. Fling</u>				14. MOTHER'S MAIDEN NAME: <u>Martha A. Walker</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>yes</u>		17. INFORMANT & ADDRESS: <u>Harvey Fling-RFD # 1 Rockville, Md.</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause		(a) <u>Coronary Occlusion</u>				5 mi.	
Antecedent cause(s)		(b) <u>Hypertensive Cardio Vascular Disease</u>				20 yr.	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		(c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>0</u>						19b. MAJOR FINDING OF OPERATION: <u>Chiriosis of Liver - 2 Portal Obstruction</u>	
19c. DATE OF OPERATION: <u>0</u>						20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town)		(County)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>John B. Ball</u>		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Jan. 8, 1956</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>1-11-56</u>		NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>		LOCATION (City, town, or county) (State) <u>Gaithersburg, Md.</u>	
DATE REC'D BY LOCAL REG. <u>1/9/56</u>		REGISTRAR'S SIGNATURE <u>Lance H. King</u>		FUNERAL DIRECTOR <u>Robert M. Humphrey</u>		ADDRESS <u>Bethesda, Md.</u>	



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

781

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00741

CERTIFICATE OF DEATH

Reg. Dist. No.

216

Items 11, 12, 13, 14, Film 192 2-2-56 et Items 3, 11, 13, 14, Film 192 2-20-56 et

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda</u>	LENGTH OF STAY (in this place) <u>5 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Chevy Chase</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hosp.</u>		STREET ADDRESS (If rural give location) <u>6408 Russin Road</u>	
3. NAME OF DECEASED: (Type or Print)		4. DATE (Month) (Day) (Year)	
(First) <u>Edith</u> (Middle) <u>B.</u> (Last) <u>Foster</u>		DEATH: <u>Jan. 26</u> 19 <u>56</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify): <u>Widow</u>	8. DATE OF BIRTH: <u>Feb. 8, 1877</u>
		9. AGE last birthday: <u>78</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Wyoming, Illinois</u>
			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME: <u>Unknown John Whitcher</u>		14. MOTHER'S MAIDEN NAME: <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.	
		17. INFORMANT & ADDRESS:	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>Acute Pulmonary Embolism</u>		<u>1 hr</u>
ANTECEDENT CAUSE (S) (B) <u>Chronic Pneumonia</u>		<u>6 days</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Cerebral Vascular Accident</u>		<u>3 days</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)	INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>Jan. 18, 1956</u> , to <u>Jan. 26, 1956</u> , that I last saw the deceased alive on <u>Jan. 26, 1956</u> , and that death occurred at <u>1:00 P.M.</u> , from the causes and on the date stated above.				
SIGNATURE <u>William C. Boucains</u>		ADDRESS <u>M. 0321, Ferguson Rd. N.W. Wash. D.C.</u>		DATE SIGNED <u>2-6-56</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>1/30/1956</u>	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State) <u>Georgia, Illinois</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/28/56</u>	REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	24. FUNERAL DIRECTOR <u>Martin W. Thompson</u>	ADDRESS <u>1300 N.W.</u>	

4-4-1941

100-1000

782

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00742

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>N. C.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Silver Spring</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Washington</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>924-Sligo Ave.</u>				STREET ADDRESS <u>5422 Nevada Ave NW</u>		(If rural give location)	
3. NAME OF DECEASED: (Type or Print) <u>Gertrude</u> (First) <u>Fox</u> (Middle) (Last)				4. DATE OF DEATH: <u>Jan. 12</u> (Month) <u>19</u> (Day) <u>56</u> (Year)			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>11-6-1879</u>	
9. AGE last birthday: <u>76</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>New Haven Conn</u>		11. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
10a. USUAL OCCUPATION Give kind of work done during most of working life even if retired <u>Retired School Teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY:			
13. FATHER'S NAME: <u>Timothy J Fox</u>				14. MOTHER'S MAIDEN NAME: <u>Theresa Healy</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If yes, give date or dates of service)				16. SOCIAL SECURITY No.: <u>No</u>		17. INFORMANT & ADDRESS: <u>Mrs. Frederick</u>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
Immediate cause (a) <u>Pulmonary edema</u>						<u>72 hours</u>	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Myocardial failure</u>						<u>2 months</u>	
(c) <u>Generalized arteriosclerosis, severe</u>						<u>3 years</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Gastro-intestinal atony</u>							
19a. DATE OF OPERATION: <u>0</u>				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? <u>Yes</u> <input type="checkbox"/> <u>No</u> <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 15, 1954</u> , to <u>Jan 12, 1956</u> , that I last saw the deceased alive on <u>Jan 11, 1956</u> , and that death occurred at <u>4:30 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>Alma M. Hurdman, M.D.</u> (Degree or title)				ADDRESS <u>3935 Baltimore St., Kensington, Md.</u>		DATE SIGNED <u>1/12/56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF <u>1-15-56</u>		NAME OF CEMETERY OR CREMATORY <u>St Bernard's Cemetery</u>		LOCATION (City, town, or county) (State) <u>New Haven Conn</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-12-56</u>		REGISTRAR'S SIGNATURE <u>Francis Potter</u>		24. FUNERAL DIRECTOR <u>The S. H. Hume Co</u>		ADDRESS <u>3801-4 N.W. Washington D.C.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL, and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Silver Spring</u>			
TOWN <u>Bethesda</u>		<u>6 days</u>		STREET ADDRESS (If rural give location)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5721 GROSVENOR PANE 8912 Walden Rd.</u>				STREET ADDRESS <u>8912 Walden Rd.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH			
<u>Russic</u> <u>-</u> <u>Fay</u>				<u>Jan</u> <u>8</u> <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE. MARRIED. WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months Days Hours Min.		
<u>F</u>	<u>W</u>	<u>married</u>	<u>Sept. 17, 1892</u>	<u>63</u> yrs.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Poland</u> <input checked="" type="checkbox"/>	
13. FATHER'S NAME: <u>Hyman Gordon</u>				14. MOTHER'S MAIDEN NAME: <u>Israh E. Isberg</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT & ADDRESS: <u>Philip Townsend - 9523 - Saybrook Ave S.S. Ind</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>acute Lobar Pneumonia</u>						<u>3 days</u>	
ANTECEDENT CAUSE (B) <u>Pyelonephritis - Cystitis</u>						<u>3 weeks</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Urinary Incontinence</u>						<u>6 weeks</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cerebrovascular Accident</u>						<u>7 weeks</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 20</u> , 19 <u>55</u> , to <u>Jan 8</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 8</u> , 19 <u>56</u> , and that death occurred at <u>3:42</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Benjamin Moncharies</u>		M.D.		ADDRESS <u>3200-16 St NW Wash. D.C.</u>		DATE SIGNED <u>Jan 8</u>	
23. BURIAL CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1/8/56</u>		<u>B'nai Israel</u>		<u>Open Hill</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/9/56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Leahy Funeral Home</u>		ADDRESS <u>4217 9th Ave</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BURNING V. S.

1000

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01916
Reg. Dist.

No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR TOWN	
TOWN <u>Bethesda</u>		<u>10 day</u>		TOWN <u>Gaithersburg</u>		<u>RFD</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hosp</u>				STREET ADDRESS (If rural, give location) <u>Metropolitan Grove</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Charles</u>				<u>June 31 1956</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>Caucasian</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH: <u>April 25, 1895</u>	
9. AGE last birthday: <u>60</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Housekeeper</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>John Moore</u>				14. MOTHER'S MAIDEN NAME: <u>Elizabeth unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>()</u> (If Yes, give war or dates of)				16. SOCIAL SECURITY No.: <u>Bradley Brothers</u>		17. INFORMANT & ADDRESS: <u>Gaithersburg, Md</u>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Shock</u>							
DUE TO							
Antecedent cause(s) (b) <u>1st & 2nd degree burn involving arms, neck and back</u>						<u>10 day</u>	
DUE TO							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc., OF INJURY) <u>Home</u>		21c. (City or town) (County) (State) <u>Gaithersburg Montg md</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>21 56 - 5:45 P.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Home caught fire & burned</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Brochant</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>2-1-56</u>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>2-4-56</u>		NAME OF CEMETERY OR CREMATORY: <u>Brownstown</u>		LOCATION (City, town, or county) (State): <u>Gaithersburg, Md</u>	
DATE REC'D BY LOCAL REG: <u>2-6-56</u>		REGISTRAR'S SIGNATURE: <u>Bernice M. Thompson</u>		24. FUNERAL DIRECTOR: <u>Robert L. Stender - Rockville Md</u>		ADDRESS:	



100-100000
100-100000
100-100000

CERTIFICATE OF DEATH

00744

Reg. Dist. No. 214

735

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Montgomery</u>		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1528 Grace Church Road</u>				STREET ADDRESS (If rural give location) <u>1528 Grace Church Road</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Rosalind</u> (Middle) (Last) <u>Frisard</u>				(Month) (Day) (Year) <u>Jan. 22, 1956</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widow</u>	8. DATE OF BIRTH <u>June 4, 1878</u>	9. AGE last birthday <u>77</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John D. Dally</u>				14. MOTHER'S MAIDEN NAME <u>Mary Alice Hines</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT & ADDRESS <u>Dorothy F. Riley- Daughter</u> <u>1528 Grace Church Road, S.S. Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Arteriosclerotic heart disease with acute congestive failure and terminal hypostatic pneumonia</u>							
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Carcinoma both lungs with extensive metastasis into the thoracic cage, primary both breasts</u>						6 years	
19a. DATE OF OPERATION <u>April 4, 1950</u>		19b. MAJOR FINDINGS OF OPERATION <u>& June 1, 1950: Bilateral mastectomy</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 3, 1950</u> , to <u>Jan. 22, 1956</u> , that I last saw the deceased alive on <u>Jan. 22, 1956</u> , and that death occurred at <u>6:00 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>J. L. Country</u>		DATE THEREOF <u>1/25/56</u>		NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>1/25/56</u>		NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
24. REC'D BY REGISTRAR <u>1/25/56</u>		REGISTRAR'S SIGNATURE <u>Frances Little</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>The S. N. Hines Co.</u> ADDRESS <u>2901 14th St., N.W.</u>			

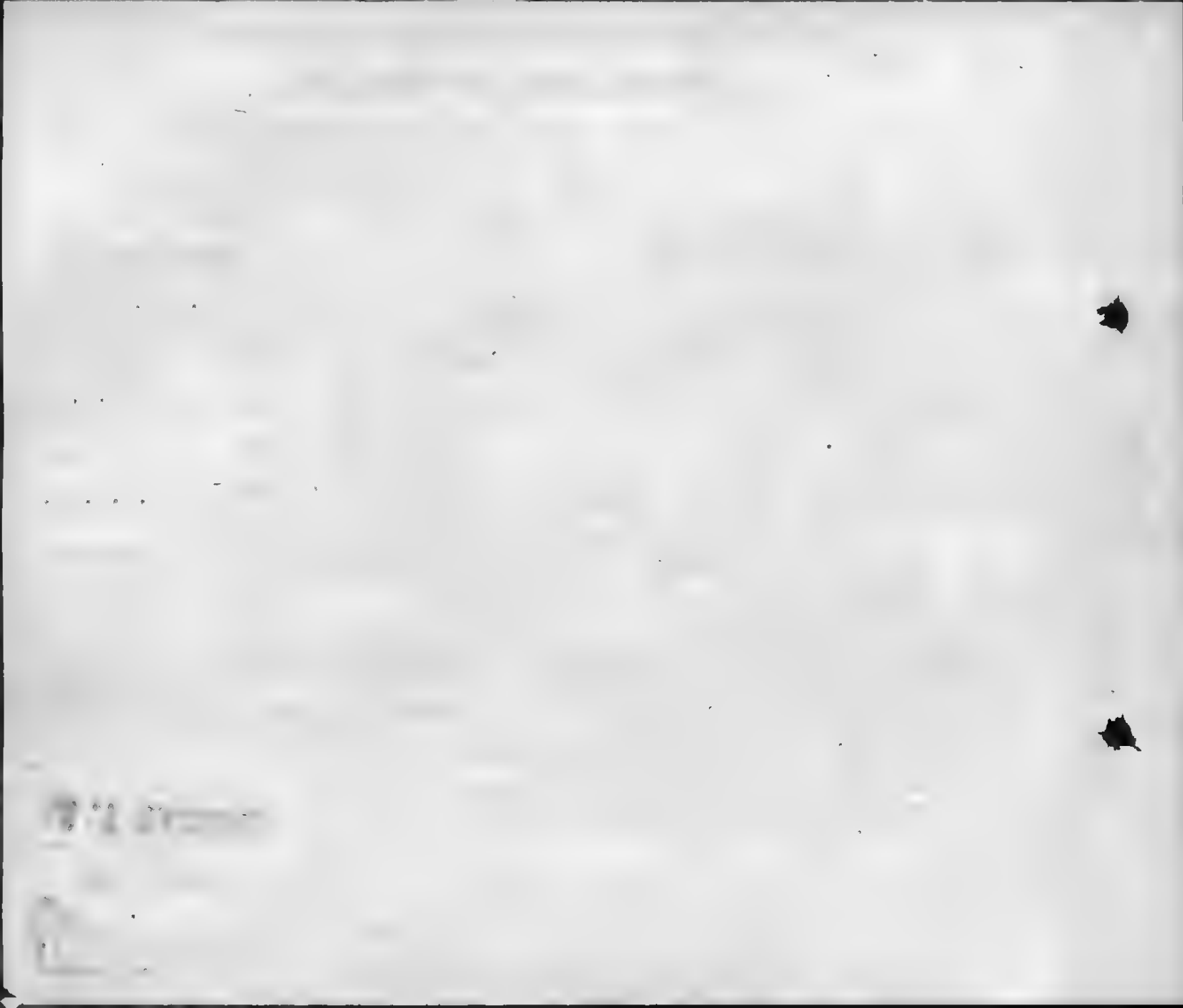
INSTRUCTIONS

1

THE ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and properly filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 111M

786

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00745

Item 8, film 191 1-21-56 et

Reg. Dist. No. 218

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Montg		MARYLAND		STATE Maryland		COUNTY Montg	
CITY (if outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (if outside corporate limits, write RURAL and give nearest town)			
TOWN Gaithersburg		60yrs		TOWN Gaithersburg			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (if rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
Charley Elmer Gartner				Jan 15 1956			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	White	Single	1892 Jan 7-1877/8	74 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Laborer. Farm		Machine Man		Ohio		U S A	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Jacob T. Gartner				Florence Staley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				Robert Gartner. Gaithersburg, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A)						12 hrs.	
ANTECEDENT CAUSE(S) DUE TO (B)						10 yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec 30, 1955, to Jan 15, 1956, that I last saw the deceased alive on Jan 15, 1956, and that death occurred at 1 P.M. from the causes and on the date stated above.							
SIGNATURE J. J. Brozchont				ADDRESS (Street, city, town, state) Gaithersburg Md		DATE SIGNED 1-16-56	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Jan 17-56		Forest Oak		Gaithersburg, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE Jan 17-56		Ernest C. Gartner		Ernest C. Gartner, Gaithersburg, Md.			



737

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

00746

Reg. Dist. No. 2, 4

1. PLACE OF DEATH- COUNTY Montgomery CITY (If outside corporate limits, write RURAL and give nearest town) Kensington HOSPITAL OR INSTITUTION OR STREET ADDRESS 3108 Ferndale Street		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Montgomery CITY (If outside corporate limits, write RURAL and give nearest town) Kensington STREET ADDRESS (If rural, give location) 3108 Ferndale Street	
3. NAME OF DECEASED (Type or Print) JOHN EARLY GATEWOOD		4. DATE OF DEATH (Month) JANUARY (Day) 15 (Year) 1956	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH Oct. 4, 1903
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operating Engineer-General Services Admr.		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) North Carolina
13. FATHER'S NAME John Gatewood		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		17. INFORMANT AND ADDRESS Mrs. Dorothy L. Gatewood, Kensington, Md.	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420. Immediate cause (a) **Coronary occlusion**

Antecedent cause(s) (b) _____
 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) _____

INTERVAL BETWEEN ONSET AND DEATH

Sudden death

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
 OF INJURY

INJURY OCCURRED
 While at work ☐ Not white at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION
 REMOVAL (Specify)
Trans. & Burial

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL
 REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

1-16-56

Frances Potter

Wagner E. Humphrey

Silver Spring, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write and give nearest town)			
TOWN <u>Toma PK.</u>		<u>3 mo-9 days</u>		TOWN <u>Silver Spring</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington San & Hosp.</u>				STREET ADDRESS (If rural give location) <u>10812 Lorain Ave.</u>			
3. NAME OF DECEASED: (Type or Print) <u>Lucy Anna Giacofei</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>January 17, 1956</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>		8. DATE OF BIRTH: <u>11-11-86</u>	
9. AGE last birthday <u>69</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>house wife</u>		11. BIRTHPLACE (State or foreign country): <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME: <u>Joseph Babich</u>				14. MOTHER'S MAIDEN NAME: <u>Ur Sula Belanich</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS: <u>Wm. J. Giacofei - 10812 Lorain Ave.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A)	<u>Carcinomatous</u>	
ANTECEDENT CAUSE (B)	<u>Carcinoma of Ovary</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Dec 54, 1954, to Jan 56, 1956, that I last saw the deceased alive on Jan 16, 1956, and that death occurred at 4:30 M, from the causes and on the date stated above.

SIGNATURE Bernard A. Jutzewski ADDRESS M. D. 9620 Old Bladenburg Rd DATE SIGNED 1-17-56

23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>1-20-56</u>	NAME OF CEMETERY OR CREMATORY <u>Beacon Hill Cemet</u>	LOCATION (City, town, or county) (State) <u>Md.</u>
DATE REC'D BY LOCAL REGISTRAR <u>Jan 18-1956</u>	REGISTRAR'S SIGNATURE <u>J. Wilson Decker</u>	24. FUNERAL DIRECTOR <u>Robert H. Matheney</u> ADDRESS <u>St SE</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 19 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:

COUNTY Montgomery MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town) Rockville Rural LENGTH OF STAY (in this place)
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Circle Dr. Glen Hills RFD #1

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Montgomery
 CITY (If outside corporate limits, write RURAL and give nearest town) Rockville Rural
 STREET ADDRESS (If rural, give location) Circle Dr. Glen Hills RFD #1

3. NAME OF DECEASED:

(First) (Middle) (Last)
MARY PENNINGTON GOVER

4. DATE OF DEATH: (Month) (Day) (Year)
Jan. 17 19 56

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.
 yrs. Months Days Hours Min.
82 7 17

Female White
 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country):

Maryland12. CITIZEN OF WHAT COUNTRY?
USA

13. FATHER'S NAME:

Charles O. Pennington

14. MOTHER'S MAIDEN NAME:

Hannah Clark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
No No

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: Son S. Clark Gover
Circle Dr. Glen Falls RFD #1 Rockville

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a) DUE TO

Congestive heart failure

INTERVAL BETWEEN ONSET AND DEATH

4 mos

Antecedent cause(s)

(b) DUE TO

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

Generalized arteriosclerosis30 yrs.

(c) DUE TO

Sensitivity10 yrs.

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 19 55, to 1/17, 19 56, that I last saw the deceased alive on 1/15, 19 56, and that death occurred at 2:30 a.m., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE) ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG. 1/23/56

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Laurel H. BradleyRobert C. Humphrey Bethesda, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



739

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN <u>Rural-Rockville</u>		OR TOWN <u>Rural-Rockville</u>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
	<u>6305 Tilden Lane</u>		<u>6305 Tilden Lane</u>

3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First)	(Middle)	(Last)	
JOHN WILSON GREEN		OF DEATH. Jan. 10, 1956	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:
Male	White	Married	Oct. 1, 1901
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY:		9. AGE last birthday
<u>Furniture Upholstering</u>	<u>Self Emp.</u>		54 yrs.
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Washington, D. C.</u>		<u>USA</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>John H. Green</u>		<u>Elzida McCeasky</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
No			
17. INFORMANT & ADDRESS:			
		<u>Cecile A. Green-Item# 2</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
420.1 IMMEDIATE CAUSE		
(A) <u>Cerebral Thrombosis</u>		<u>Instant</u>
DUE TO		
ANTECEDENT CAUSE (S)		
(B) <u>Hypertension with Aneurysm</u>		<u>10 yrs</u>
DUE TO		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
-------------------------	----------------------------------	--

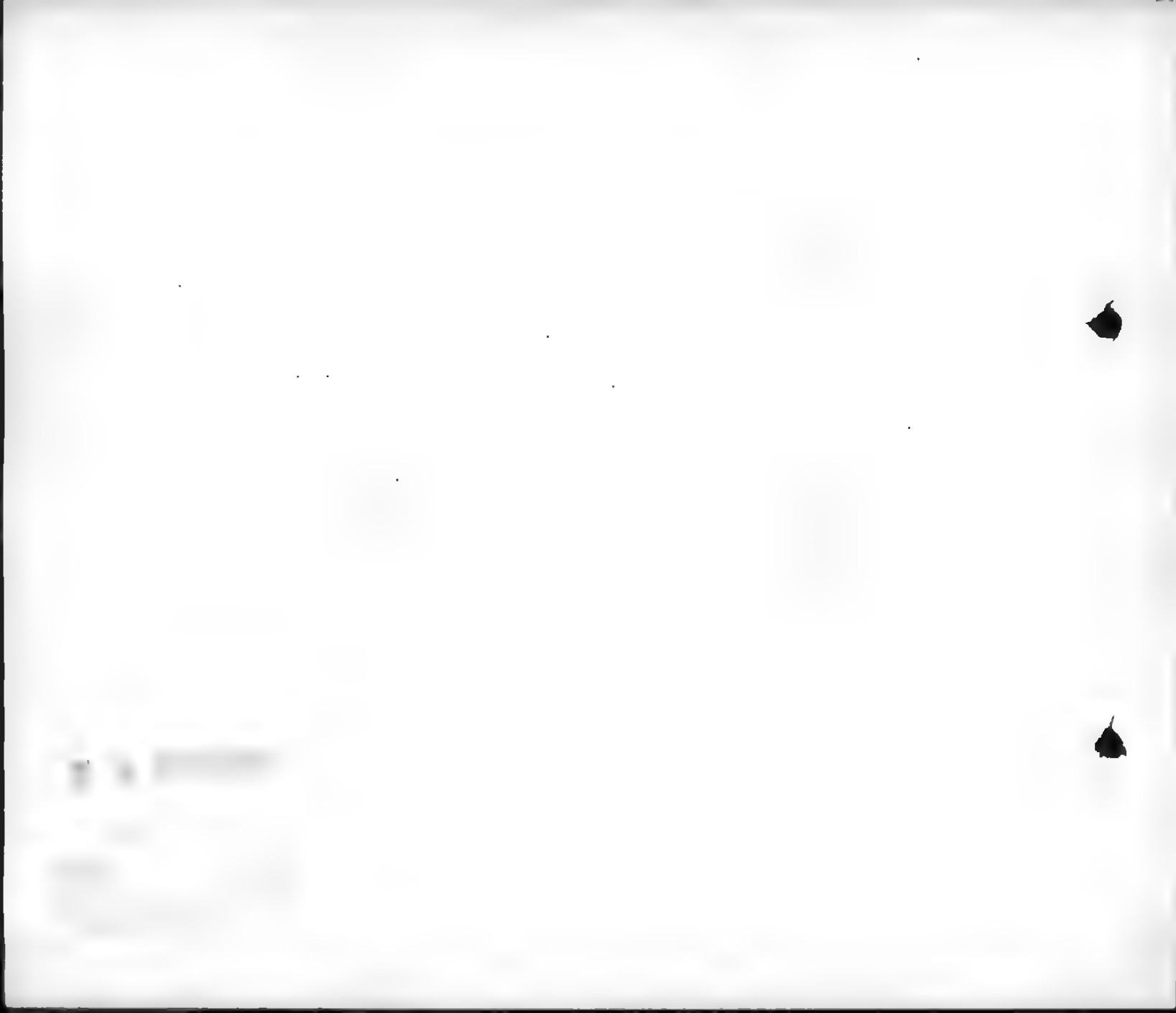
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from <u>Jan</u> , 1955, to <u>Jan</u> , 1956, that I last saw the deceased alive on <u>Jan 4</u> , 1956, and that death occurred at <u>6 P. M.</u> from the causes and on the date stated above.		
SIGNATURE <u>[Signature]</u>	ADDRESS <u>M.D. 1016 Georgetown Rd.</u>	DATE SIGNED <u>1/11/56</u>

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>1-13-56</u>	<u>Parklawn</u>	<u>Rockville, Md.</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	FUNERAL DIRECTOR	ADDRESS
<u>1/12/56</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>Bethesda, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00750

Item 14, Film 191 1-16-56 et

713

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH. <u>EVENTIDE NURSING HOME</u> <u>700 HUDSON AVENUE</u> COUNTY <u>MONTGOMERY CTY. MARYLAND</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>TAKOMA PARK</u> LENGTH OF STAY (in this place) <u>2 DAYS</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>EVENTIDE NURSING HOME</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: <u>8501 LYNWOOD PLACE CHEVY CHASE MD.</u> STATE <u>MD.</u> COUNTY <u>MONTGOMERY</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>CHEVY CHASE MD.</u> STREET ADDRESS (If rural give location) <u>8501 LYNWOOD PL.</u>	
3. NAME OF DECEASED: (Type or Print) <u>MARY</u> (First) <u>ISABEL</u> (Middle) <u>GREEN</u> (Last)		4. DATE OF DEATH: <u>JAN.</u> (Month) <u>7</u> (Day) <u>1956</u> (Year)	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOW</u>	8. DATE OF BIRTH: <u>1864</u>
9. AGE last birthday <u>91</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>HOUSEWIFE</u>	11. BIRTHPLACE (State or foreign country): <u>EASTERN SHORE OF MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME: <u>HESSEY</u>	
14. MOTHER'S MAIDEN NAME: <u>Mary Louise Anthony</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO.</u> (If Yes, give war or dates of service)	
16. SOCIAL SECURITY No. <u>NONE.</u>		17. INFORMANT & ADDRESS: <u>MRS. PATRICIA GREEN ROGERS.</u> <u>8501 LYNWOOD PL. CHEVY CHASE, MD.</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>CORONARY THROMBOSIS</u>			<u>FEW SECONDS.</u>
ANTECEDENT CAUSE (B) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>			<u>30 YRS.</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>440X</u>			
(C) <u>RECENT LOBAR PNEUMONIA</u>			<u>1 MONTH</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>NONE</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>DEC. 11., 1955</u> , to <u>JAN. 6., 1956</u> that I last saw the deceased alive on <u>JAN. 6., 1956</u> , and that death occurred at <u>1:20 PM</u> , from the causes and on the date stated above. SIGNATURE <u>Joseph P. Connor</u> ADDRESS <u>BETHESDA, MD.</u> DATE SIGNED <u>7 Jan. 1956</u> M. D. <u>9600 OLD GEORGETOWN RD.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. FUNERAL DIRECTOR	
DATE REC'D BY LOCAL REGISTRAR <u>Jan 7 1956</u>		REGISTRAR'S SIGNATURE <u>William Dodd</u>	
LOCATION (City, town, or county) (State) <u>Centerville Md</u>		ADDRESS <u>Joseph Hawley's Sons Wash. D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11

В. А. СЕВЕРОВ

М. 1911

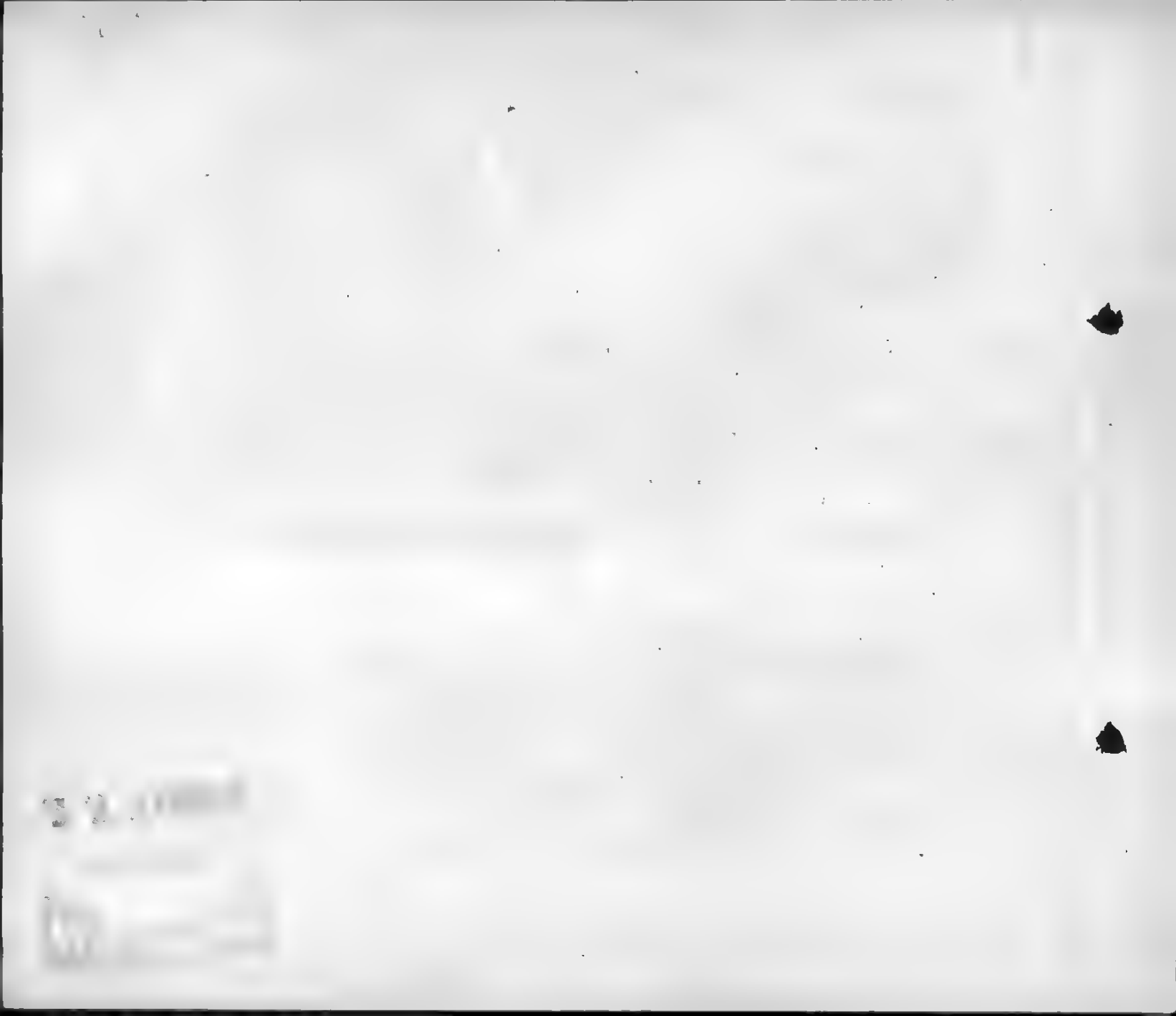
790
CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u> MARYLAND				STATE <u>Dist. of Col.</u> COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town)				CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Bethesda</u>				OR TOWN <u>Washington</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hosp -</u>				STREET ADDRESS (If rural give location) <u>4641 Greene Pl. N.W.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Mary Alice Greene</u>				<u>Jan. 14 1956</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>Widow</u>	<u>Oct. 14, 1873</u>	<u>82</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>				<u>Wooden Co., Virginia</u>		<u>U.S.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Josephus Hospital</u>				<u>Mary Catherine Costello</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
						<u>Mrs. W^m C. Hazel, daughter (same)</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE				(A) DUE TO <u>Cerebral Hemorrhage</u>			
ANTECEDENT CAUSE (B):				(B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1/11/56</u> , 19 <u>56</u> , to <u>1/14/56</u> , that I last saw the deceased alive on <u>1/14</u> , 19 <u>56</u> , and that death occurred at <u>8:45 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Edna E. Anderson</u>				DATE SIGNED <u>1/14/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1/16/56</u>		<u>Union Cemetery</u>		<u>Leesburg, Virginia.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>1-16-56</u>		<u>Bessie M. Thompson</u>		<u>Joseph F. Birch's Son, Jr., D.C.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH

Reg. Dist. No. 223...

716

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH.			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Montgomery</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>12th</u> TOWN <u>Takoma Park</u> (In this place) HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington San and Hosp</u> <u>7600 Carroll Ave</u>			STATE <u>Maryland</u> COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Takoma Park</u> STREET ADDRESS (If rural give location) <u>Takoma Park</u> <u>7600 Carroll Ave</u>		
3. NAME OF DECEASED: (Type or Print) <u>May</u> (First) <u>Greer</u> (Middle) (Last)			4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan</u> <u>29</u> <u>1956</u>		
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH: <u>2-23-78</u>	9. AGE last birthday: <u>77</u> yrs. <u>11</u> Months <u>6</u> Days <u>12</u> Hours <u>12</u> Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Indiana</u>	12. CITIZEN OF WHAT COUNTRY? <u>American</u>
13. FATHER'S NAME: <u>Henderson Mrs Jonathan</u>			14. MOTHER'S MAIDEN NAME: <u>Miller Mrs Mary</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u> (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>NONE</u>		
17. INFORMANT & ADDRESS: <u>Washington San and Hosp</u> <u>Washington</u> <u>1600 Carroll Ave Takoma Park</u> <u>Ind. D.C.</u>					
18. MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>					<u>Terminal</u>
ANTECEDENT CAUSE (B) <u>Hypertension</u>					<u>Unknown</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Arteriosclerosis</u>					<u>Unknown</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1-21, 1956</u> , to <u>1-29, 1956</u> that I last saw the deceased alive on <u>1-29, 1956</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.					
SIGNATURE <u>Robert A. Hare</u>		ADDRESS <u>M.D. Takoma Park, Md</u>		DATE SIGNED <u>1/29/56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF <u>Feb 1st 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cem</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-29-1956</u>		REGISTRAR'S SIGNATURE <u>Robert A. Hare</u>		24. FUNERAL DIRECTOR <u>A.H. Harris Co.</u> <u>Washington D.C.</u>	

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

791

CERTIFICATE OF DEATH

Reg. Dist. No.

00753

1. PLACE OF DEATH.				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bethesda</u> LENGTH OF STAY (in this place) <u>26 hrs</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Resmor Sanitarium</u> <u>5721 Grosvenor Lane</u>				STREET ADDRESS (If rural give location) <u>4402 Winston Dr.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) Blanche Crillo				4. DATE (Month) (Day) (Year) OF DEATH <u>Jan. 25 1956</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>Feb. 17, 1875</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Cincinnati Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Samuel Bolles</u>				14. MOTHER'S MAIDEN NAME: <u>Sarah Bosworth</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT & ADDRESS: <u>Records at Sanitarium</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) DUE TO <u>Carcinoma, ovary & widespread metastases</u>				INTERVAL BETWEEN ONSET AND DEATH <u>18 MOS</u>			
ANTECEDENT CAUSE (B) DUE TO <u>(confirmed by PAP smear)</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE LAST STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>arteriosclerotic Heart disease 20 yrs</u>							
19A. DATE OF OPERATION: <u>none</u>		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>OCT.</u> , 19 <u>55</u> , to <u>present</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>1/25, 1956</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Charles J. Savarese, Jr.</u>		M.D. <u>4861 BATTERY LA</u>		BETH DATE SIGNED <u>1/25/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/27/56</u>		NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cem</u>		LOCATION (City, town, or county) (State) <u>Prince Georges Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-25-56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>The Holmes Co</u> ADDRESS <u>2901-14th St. N.W. Washington D.C.</u>			

1956

792

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00754

CERTIFICATE OF DEATH

Reg. Dist. No. 211

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNT <u>Montg.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural - Woodfield</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural - Woodfield</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.F.D. # 1 Gaithersburg</u>				STREET ADDRESS (If rural give location) <u>R.F.D. #1 Gaithersburg</u>			
3. NAME OF DECEASED:				4. DATE OF DEATH:			
(First) <u>Samuel</u>		(Middle) <u>Floyd</u>		(Last) <u>Grimes</u>		(Month) (Day) (Year) <u>Jan. 17 19 56</u>	
(Type or Print)							
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>Dec. 5, 1894</u>	
						9. AGE last birthday: <u>61</u> yrs.	
						IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired. <u>Retired Building Contractor</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>Montg. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Samuel T. Grimes</u>				14. MOTHER'S MAIDEN NAME: <u>Annie Jane Beall</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No.</u>		16. SOCIAL SECURITY No.: <u>None</u>		17. INFORMANT & ADDRESS: <u>Mrs Bertie W. Grimes, Gaithersburg, Md.</u>			
(If Yes, give war or dates of service)							
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				Interval Between Onset And Death			
Immediate cause (a) <u>442X Hypertensive - Cardiac - Vascular</u>				<u>Months</u>			
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Renal disease as manifested by acute left ventricular failure</u>				<u>20 years</u>			
DUE TO (c)							
11. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE (Specify)				PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Mar. 1954</u> , to <u>Jan. 17, 1956</u> , that I last saw the deceased alive on <u>Jan. 17, 1956</u> , and that death occurred at <u>11:02 p.m.</u> ; from the causes and on the date stated above.							
SIGNATURE (Degree or title) <u>Jack Schumacher M.D.</u>				ADDRESS DATE SIGNED <u>Gaithersburg, Md. Jan. 18 56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Jan. 20, 1956</u>		<u>Wesley Grove</u>		<u>Woodfield, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Jan. 19, 1956</u>		<u>Della W. Burdette</u>		<u>Olin L. Molesworth</u>		<u>Damascus, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

DOMINGO A. S.

793

CERTIFICATE OF DEATH

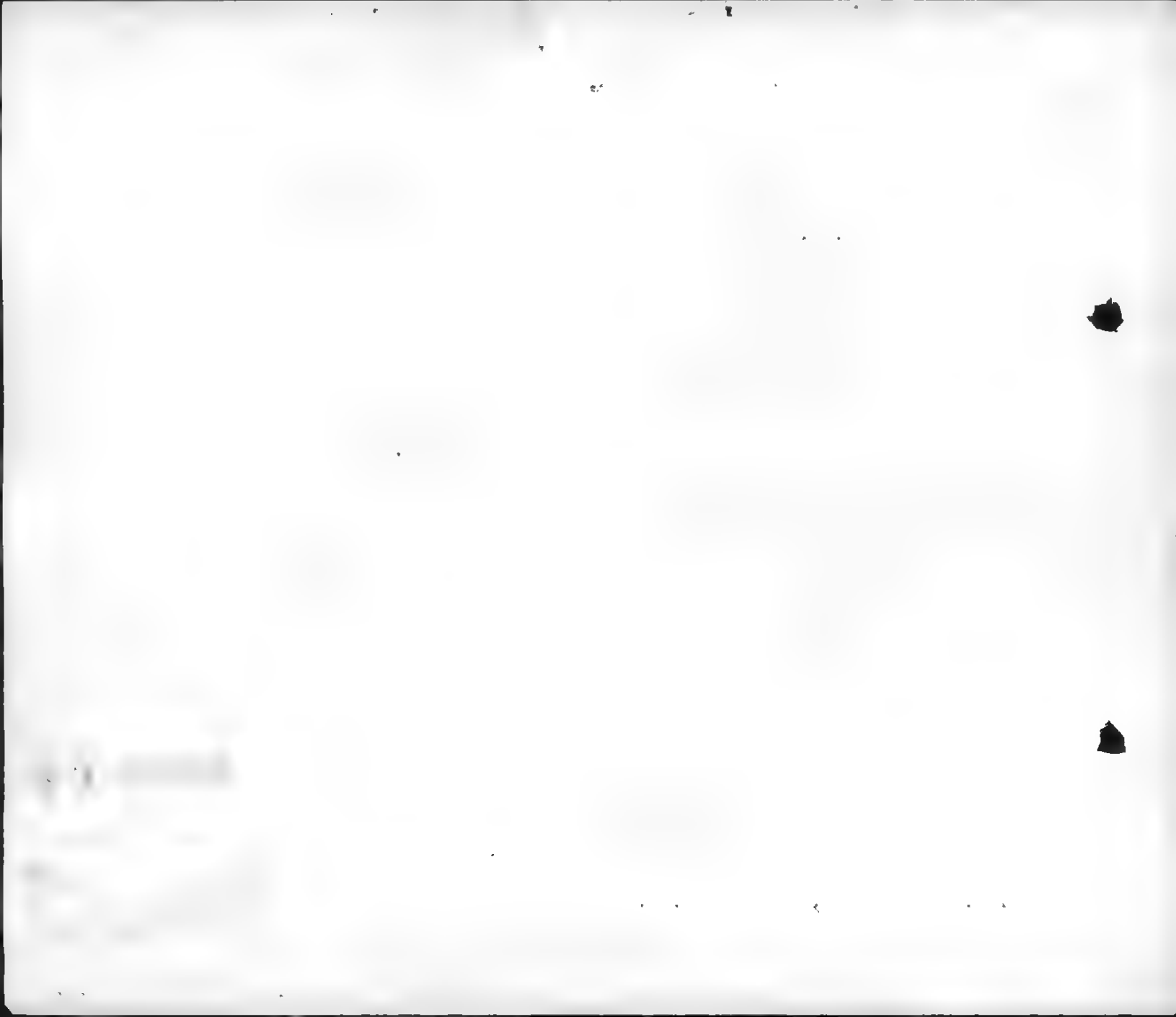
Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Montgomery		MARYLAND		STATE Maryland		COUNTY Montgomery	
CITY (If outside corporate limits, write RURAL and give nearest town) Bethesda Rural		LENGTH OF STAY (in this place) 18 days		CITY (If outside corporate limits, write RURAL and give nearest town) Silver Spring		56	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital				STREET ADDRESS (If rural give location) 12122 Selfridge Road		1	
3. NAME OF DECEASED: (First) (Middle) (Last) Lyman Walter GUILFORD				4. DATE (Month) (Day) (Year) OF DEATH: January 9 19 56			
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 4-26-92	9. AGE last birthday 63 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman			10B. KIND OF BUSINESS OR INDUSTRY: Retail	11. BIRTHPLACE (State or foreign country): Iowa		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME: William GUILFORD				14. MOTHER'S MAIDEN NAME: Maude E. ALLEN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service) Yes WW I			16. SOCIAL SECURITY NO. Unknown		17. INFORMANT & ADDRESS: Wife Mrs. Nannamari GUILFORD same as above		
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) 420.0 Congestive failure							undef.
ANTECEDENT CAUSE (B) ASHD & Myocardial infarction							undef.
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Coronary occlusion							undef.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Lobar pneumonia							undef.
19A. DATE OF OPERATION: 2			19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 9 Jan 19 56 to 9 Jan 19 56 , that I last saw the deceased alive on 9 Jan 19 56 and that death occurred at 8:20A , from the causes and on the date stated above. SIGNATURE B. S. YURICK LTJG, MC, USNR U. S. Naval Hospital, NNMC, Bethesda, Maryland ADDRESS DATE SIGNED							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12 Jan 56		NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		LOCATION (City, town, or county) (State) Arlington, Virginia	
DATE REC'D BY LOCAL REGISTRAR 10 Jan 1956		REGISTRAR'S SIGNATURE Mary E. Canally		24. FUNERAL DIRECTOR'S ADDRESS Chambers Funeral Home 517 11th Street, S.E. Washington, D.C.			

MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

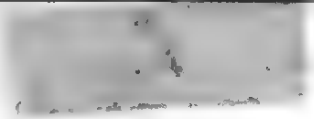
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784

CERTIFICATE OF DEATH

Reg. Dist. No. 216.....

1. PLACE OF DEATH.		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY MONTGOMERY	MARYLAND	STATE N.C.	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN SUMNER HIGHLAND APT.	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN DUNN	72 x -
HOSPITAL OR INSTITUTION OR STREET ADDRESS 4513 SANGAMORE RD.		STREET ADDRESS (If rural give location) ROUTE #4	
3. NAME OF DECEASED: (Type or Print) SARHA E HAMILTON		4. DATE (Month) (Day) (Year) OF DEATH: 1 19 1956	
5. SEX: F	6. COLOR OR RACE: W	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify): WIDOWED	8. DATE OF BIRTH: 6/22/1869
9. AGE last birthday: 86 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	11. IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): NORTH CAROLINA
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME: RANDALL SMITH	
14. MOTHER'S MAIDEN NAME: ? MATHEWS		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) NO NONE	
16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: MRS VAUGHAN 6524-79th ST. CABIN JOHN, MD.	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
4. IMMEDIATE CAUSE (A) acute coronary thrombosis			
ANTECEDENT CAUSE (S) DUE TO Hypertension			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan. 5 to Jan. 19, 1956 , that I last saw the deceased alive on Jan. 19, 1956 , and that death occurred at 11:15 M. from the causes and on the date stated above.			
SIGNATURE Andrew E. Medsai		ADDRESS 1720 Woodlawn Dr DATE SIGNED 1/20/56	
23. BURIAL. CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 1/21/56	
NAME OF CEMETERY OR CREMATORY GREENWOOD CEM.		LOCATION (City, town, or county) DUNN, N.C.	
DATE REC'D BY LOCAL REGISTRAR 1-20-56		REGISTRAR'S SIGNATURE James M. Thompson	
FURNERAL DIRECTOR The J. H. Hines Co		ADDRESS 2901-14th St NW Washington, DC	



U.S. GOVERNMENT

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct name is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00757

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>District of Columbia</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>National Institutes of Health</u>				STREET ADDRESS (If rural, give location) <u>4603 Lewis Ave</u>			
3. NAME OF DECEASED:				4. DATE OF DEATH:			
(First) <u>Ernest</u>		(Middle) <u>—</u>		(Last) <u>Hancock</u>		(Month) <u>2</u> (Day) <u>19</u> (Year) <u>56</u>	
5. SEX: <u>male</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED: <u>married</u>		8. DATE OF BIRTH: <u>Oct 14, 1890</u>	
9. AGE last birthday: <u>65</u> yrs.		10. MONTHS <u>—</u> DAYS <u>—</u> HOURS <u>—</u> MIN. <u>—</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>caretaker</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>Cemetery</u>			
13. FATHER'S NAME: <u>Robert Hancock</u>				14. MOTHER'S MAIDEN NAME: <u>Elizabeth Caywood</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>				16. SOCIAL SECURITY No.: <u>5 770 7974B</u>		17. INFORMANT & ADDRESS: <u>Patient on admission</u>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
Immediate cause (a) <u>Anuria and hypotension - unknown cause</u>						<u>days</u>	
Antecedent causes (s) (b) <u>Myeloma, Multiple</u>						<u>4 months</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>bilateral lower lobe broncho pneumonia</u>						<u>days</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <u>11/2</u>						19b. MAJOR FINDINGS OF OPERATION: <u>bilateral lower lobe broncho pneumonia</u>	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/1</u> , 19 <u>55</u> , to <u>11/2</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11/2</u> , 19 <u>56</u> , and that death occurred at <u>11:10 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Hubert G. Lusk Jr.</u>				ADDRESS <u>M.D. N.C.I Bethesda, Md.</u>			
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>burial</u>		<u>Jan 4, 1956</u>		<u>Cedar Hill Cemetery</u>		<u>Southland Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>1/3/56</u>		<u>Bessie M. Thompson</u>		<u>Summers Bros</u>		<u>1661 - good hope rd S.E. Wash, D.C.</u>	

BUREAU V. S.

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CERTIFICATE OF DEATH

Reg. Dist. No. 223-

1. PLACE OF DEATH:

COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) Laurel Park LENGTH OF STAY (in this place) 38 hrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Wash. Sanatorium & Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) Silver Spring
STREET ADDRESS (If rural, give location) 8009 Piney Branch Rd.

3. NAME OF DECEASED:

(First) Mabel (Middle) Muriel (Last) Hannah

4. DATE OF DEATH: (Month) 1 (Day) 17 (Year) 1956

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH:

9. AGE last birthday: (If under 1 year) (If under 24 hrs.)

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Illinois

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME:

George Witwer

14. MOTHER'S MAIDEN NAME:

Adelaide Gregory

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service) No

16. SOCIAL SECURITY No.: —

17. INFORMANT & ADDRESS:

Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a) Cerebral hemorrhage

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) Hypertension

DUE TO

(c) Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

21 hrs

Indefinite

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....m., from the causes and on the date stated above.

SIGNATURE

Edmund L. Burnett, M.D. - 7701-Carroll Ave. Takoma Park Md

DATE SIGNED

1/17/56

23. BURIAL, CREMATION REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Funeral Home 191450 Rockwell Rd. Rockville Md
Deal Funeral Home 4812 Pa Ave Washington D.C

MARGIN RESERVED FOR BINDING

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 19 1956

RECEIVED

712

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Montgomery</u>	MARYLAND		STATE <u>MD</u>	COUNTY <u>Dist. of Columbia</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>17 Skoma Park</u>	LENGTH OF STAY (In this place) <u>31 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>1930 Columbia Rd. N.W.</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. Sanatorium & Hospital</u>			STREET ADDRESS (If rural give location)		
3. NAME OF DECEASED: (Type or Print) <u>Fred</u> <u>Bernard</u> <u>Harper</u>			4. DATE (Month) (Day) (Year) OF DEATH: <u>1</u> - <u>20</u> 19 <u>56</u>		
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Caucasian</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH: <u>1-16-90</u>		
9. AGE last birthday <u>66</u> yrs.			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Broker. Investor. Broker</u>		
11. BIRTHPLACE (State or foreign country): <u>DC</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME: <u>James Harper</u>			14. MOTHER'S MAIDEN NAME: <u>Lavinia Baeschlin</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes. W.W.I.</u>			16. SOCIAL SECURITY NO. <u>-</u>		
17. INFORMANT & ADDRESS: <u>Hospital Records</u>					

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>Post-operative hemorrhage (Transurethral prostatectomy)</u>	DUE TO	<u>18 hours.</u>
ANTECEDENT CAUSE (B) <u>AFIBRINOGENAEMIA</u>	DUE TO	
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cerebrovascular Accident</u>		

19A. DATE OF OPERATION: <u>1.19.56</u>	19B. MAJOR FINDINGS OF OPERATION: <u>Prostatic Hypertrophy</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/10, 1955, to 1/20, 1956, that I last saw the deceased alive on 1/19, 1956, and that death occurred at 4:40 A.M., from the causes and on the date stated above.

23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>		DATE THEREOF <u>1/23/56</u>	NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>	LOCATION (City, town, or county) (State) <u>Washington, DC</u>
DATE REC'D BY LOCAL REGISTRAR <u>Jan-20-1956</u>	REGISTRAR'S SIGNATURE <u>Herbert A. Goldberg</u>	24. FUNERAL DIRECTOR <u>Francis Collins</u>		ADDRESS <u>1835 E St. N.W., D.C. 1-20-56</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Virginia</u>		COUNTY <u>Fairfax</u>	
CITY (If outside corporate limits, write TOWN and give nearest town) <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>29 days</u>		CITY (If outside corporate limits, write TOWN and give nearest town) <u>Herndon</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center Nat'l Institutes of Health</u>				STREET ADDRESS (If rural give location) <u>Route # 2</u>			
3. NAME OF DECEASED: (First) <u>Stephen</u> (Middle) <u>Olden</u> (Last) <u>Harrison</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>January 20, 1956</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>May 17, 1954</u>	
9. AGE last birthday <u>1</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Child</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>- -</u>		11. BIRTHPLACE (State or foreign country): <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME: <u>Walter Harrison</u>				14. MOTHER'S MAIDEN NAME: <u>Evelyn Harrison</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>The medical record, The Clinical Center</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>acute + chronic pneumonia</u>		
ANTECEDENT CAUSE (B) <u>chronic bronchitis + bronducts</u>		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>subacute disease of pancreas</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION: <u>None</u>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>none</u>	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 22, 19 55 to Jan 20, 19 56, that I last saw the deceased alive on Jan 20, 19 56, and that death occurred at M, from the causes and on the date stated above.

23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal + Burial</u>		DATE THEREOF <u>Jan 21, 1956</u>	NAME OF CEMETERY OR CREMATOR <u>Chestnut Grove Cemetery</u>	LOCATION (City, town, or county) (State) <u>Herndon, Virginia</u>
DATE REC'D BY LOCAL REGISTRAR <u>1/23/56</u>	REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	24. FUNERAL DIRECTOR <u>Red-Green Funeral Home</u> ADDRESS <u>Herndon, Virginia</u>		

MARGIN RESERVED FOR FILING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 25 19

BUREAU V. S.

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INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

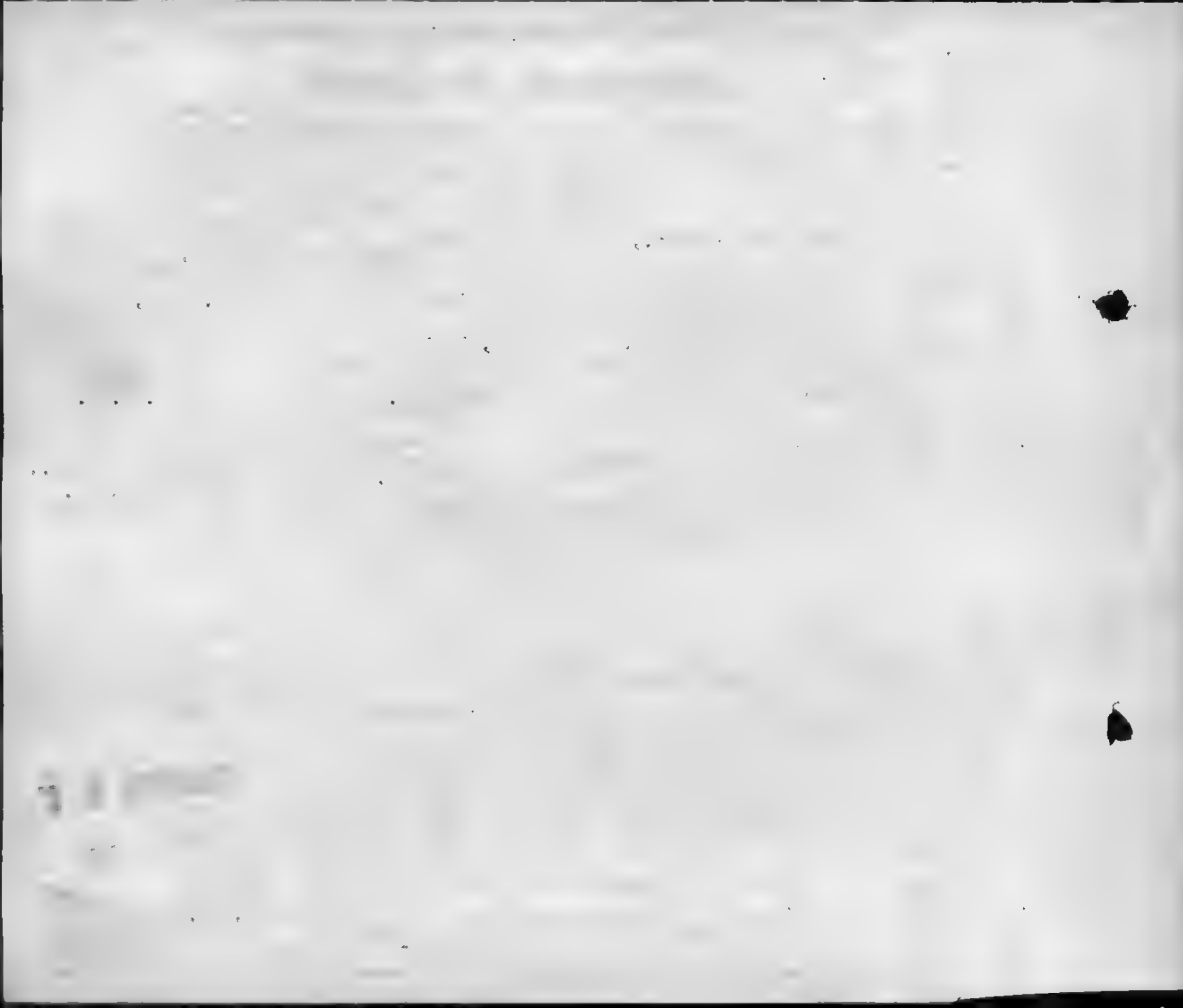
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00761

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Montgomery		MARYLAND		STATE Maryland		COUNTY Montgomery	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Chevy Chase		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Chevy Chase			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 8818 Hawkins Lane.,				STREET ADDRESS (If rural give location) 8818 Hawkins Lane.,			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Emily (Middle) (Last) Hawkins				(Month) (Day) (Year) Jan. 21, 19 56			
5. SEX Female	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH July 22, 1871	9. AGE last birthday 84 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Bradley Carroll				14. MOTHER'S MAIDEN NAME Hariett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Ella C. Hawkins 8818 Hawkins Lane., Chevy Chase, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) Cerebro-vascular-accident						INTERVAL BETWEEN ONSET AND DEATH 1 wk	
ANTECEDENT CAUSE(S) DUE TO (B) corebral arteriosclerosis						5 yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Broncho pneumonia							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1-4 , 19 56 , to 1-21 , 19 56 , that I last saw the deceased alive on 1-21 , 19 56 , and that death occurred at 2:30 p.m. from the causes and on the date stated above.							
SIGNATURE Donathey Sill				ADDRESS (Street, city, town, state) M.D. 7511 Arlington Rd. Bethesda 14, Md 20812		DATE SIGNED: 1/21/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 1/24/56		NAME OF CEMETERY OR CREMATORY Lincoln Memorial		LOCATION (City, town, or county) (State) Suitland, Md.	
24. REC'D BY REGISTRAR DATE 1-26-56		REGISTRAR'S SIGNATURE Bessie M. Thompson		25. FUNERAL DIRECTOR'S SIGNATURE Robert L. Smother - Rockville Md.		ADDRESS	



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

798

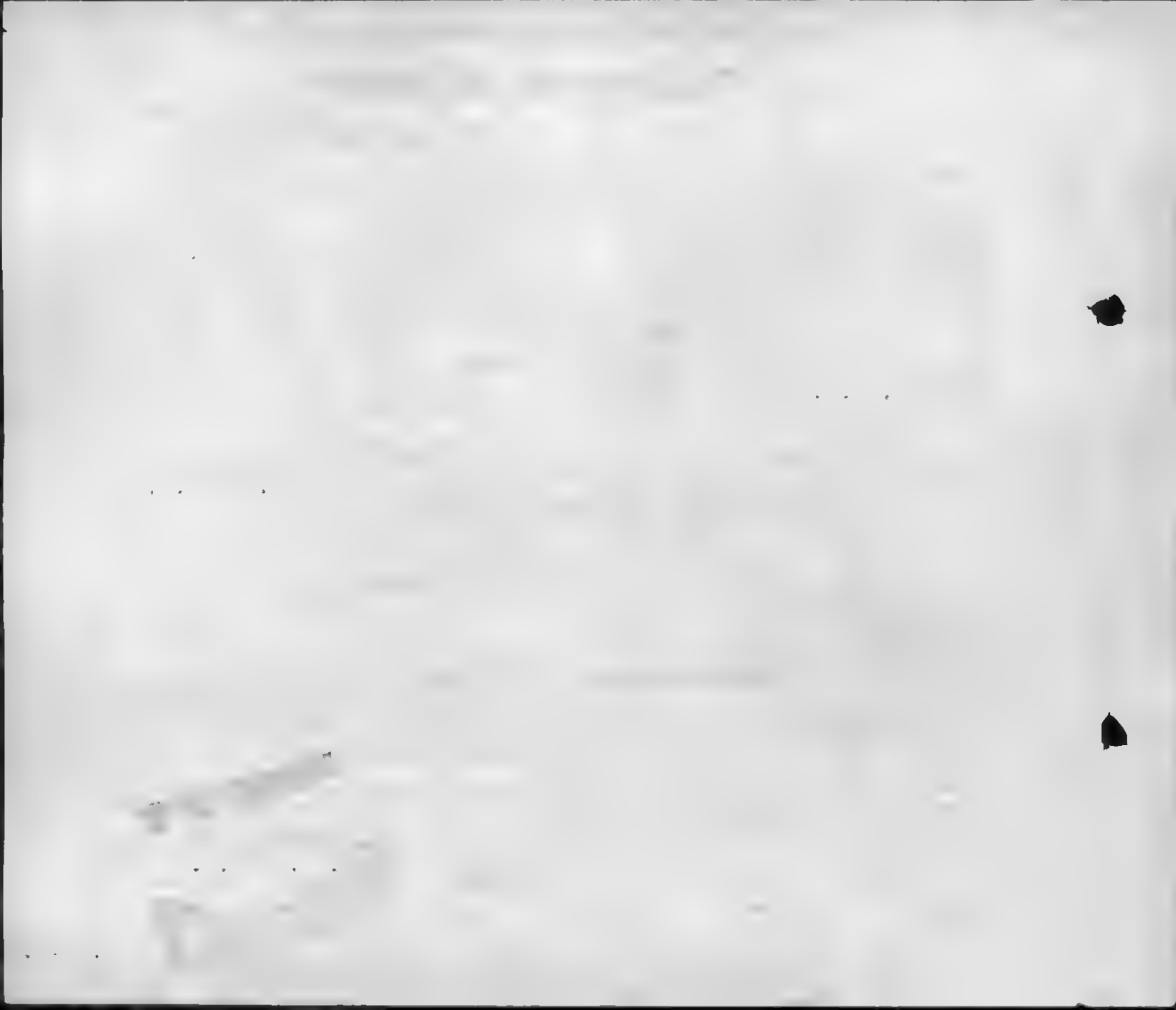
CERTIFICATE OF DEATH

00762

214

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Montgomery</u>		STATE <u>MARYLAND</u>		STATE <u>D.C.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
TOWN				TOWN <u>Washington</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14511 Colesville Rd.</u>				STREET ADDRESS (If rural give location) <u>719 8th St. N.E.</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>ROBERT</u> <u>HAYES</u>				<u>1</u> <u>4</u> <u>56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>M</u>	<u>White</u>	<u>Widowed</u>	<u>July 17, 1876</u>	<u>79</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Ret. D.C. Govt</u>		<u>Fireman</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Unknown</u>				<u>Ellen Hayes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Yes</u>		<u>None</u>		<u>Mrs Lillie Stack</u> <u>719 8th St. N.E. D.C.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Acute Coronary Occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 Min.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March</u>, 19<u>54</u>, to <u>Dec 26</u>, 19<u>55</u>, that I last saw the deceased alive on <u>Dec 26</u>, 19<u>56</u>, and that death occurred at <u>11:00</u> M., from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>2902 Porter St. N.W. D.C.</u>			
				DATE SIGNED <u>1-4-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1-6-56</u>		<u>Cedar Hill Cemetery</u>		<u>Suitland, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>1-10-56</u>		<u>Francis [Signature]</u>		<u>[Signature]</u>		<u>308 4th St. N.E.</u>	



CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH: COUNTY <u>Montgomery County</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda Rural</u> TOWN <u>Bethesda Rural</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S. Naval Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>So. Carolina</u> COUNTY _____ CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Beaufort</u> STREET ADDRESS (If rural give location) <u>P.O. Box 129</u>	
3. NAME OF DECEASED: (Type or Print) <u>James</u> (First) <u>Paul</u> (Middle) <u>HENDRICKS</u> (Last)		4. DATE (Month) (Day) (Year) OF DEATH: <u>January 14</u> 19 <u>56</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Cauc</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>June, 1, 1915</u>
9. AGE last birthday <u>40</u> yrs.		10. IF UNDER 1 YEAR: Months _____ Days _____	
11. IF UNDER 24 HRS. Hours _____ Min. _____			
10A. USUAL OCCUPATION (Give kind of work done during most of working life.) <u>U.S. MARINE CORPS</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>U.S. MARINE CORPS</u>	
11. BIRTHPLACE (State or foreign country): <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>James Robert HENDRICKS</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Jane</u>	
15. WAS DECEASED EVER IN U.S. ARMY, NAVY, AIR FORCE, MARINE CORPS, OR COAST GUARD? (Yes, no, or unk.) (If Yes, give war or dates) <u>Yes U.S.M.C. Since 11-2-36</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT & ADDRESS: <u>Beaufort, S.C.</u> <u>Wife: Marie HENDRICKS, P.O. Box 129,</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Medullary Compression</u>			
ANTECEDENT CAUSE (B) <u>Glioblastoma Multiforme</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Lobular Pneumonia</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>1-14-56</u>	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____ M.	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>14 Jan., 1956</u> , to <u>14 Jan., 1956</u> , that I last saw the deceased alive on <u>14 Jan.</u> 19 <u>56</u> , and that death occurred at <u>5:10 P.M.</u> , from the causes and on the date stated above. SIGNATURE <u>Gerald I. Shugoll</u> ADDRESS _____ DATE SIGNED _____ <u>Gerald I. Shugoll LTJG, MC, USN U. S. Naval Hospital, NMM, Bethesda, Maryland</u>			
23. BURIAL, CREMATION, (SPECIFY) <u>BURIAL</u>	DATE THEREOF <u>18 Jan 1956</u>	NAME OF CEMETERY OR CREMATORY <u>EVERGREEN CEMETERY</u>	LOCATION (City, town, or county) (State) <u>Beaufort, South Carolina</u>
DATE REC'D BY LOCAL REGISTRAR <u>16 Jan 1956</u>	REGISTRAR'S SIGNATURE <u>Mary E. Cassell</u>	24. FUNERAL DIRECTOR <u>R.A. PUMPHREY</u>	ADDRESS <u>7557 Wisconsin Ave. Bethesda, Maryland</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



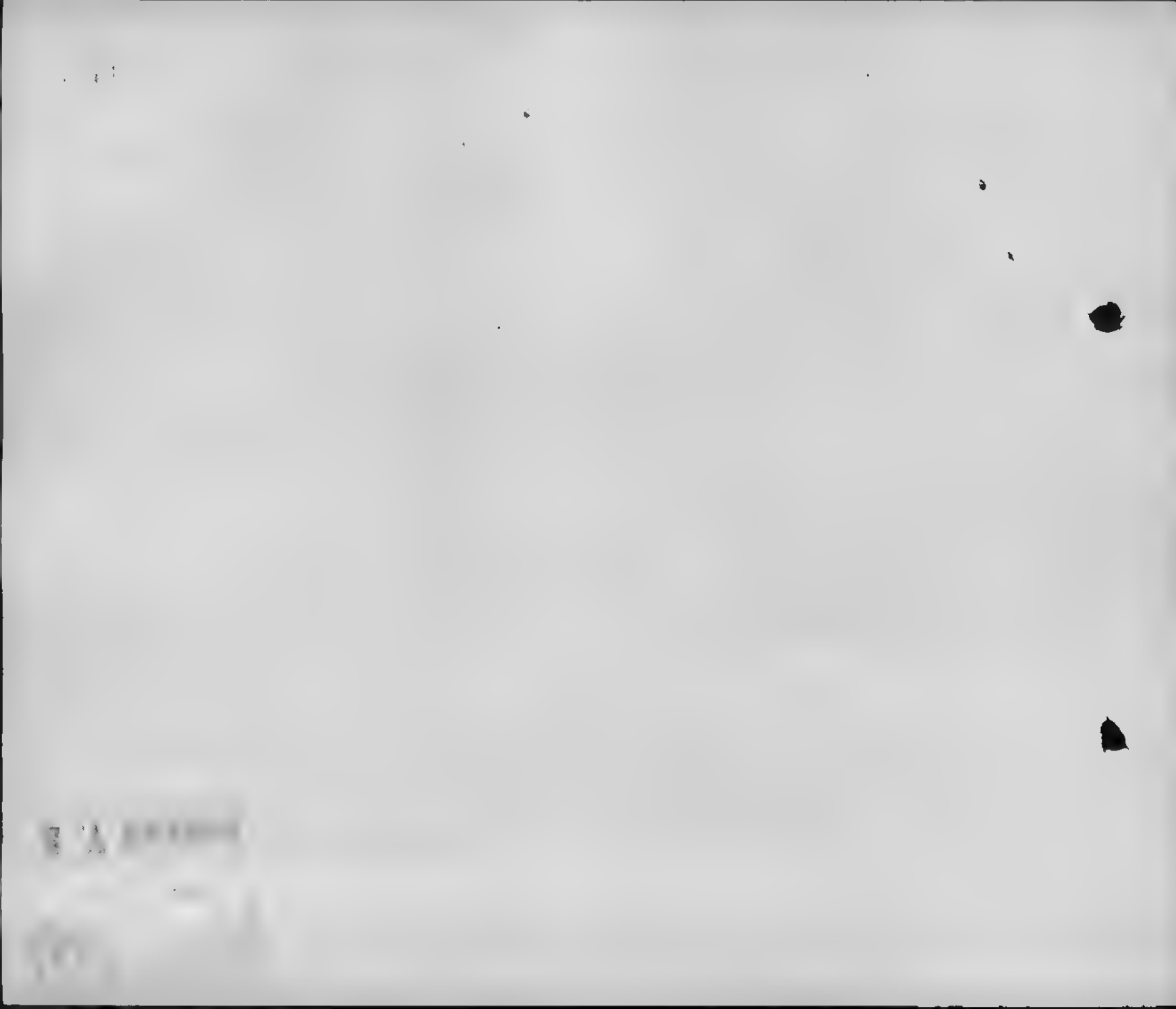
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. **00764**
No. **216**

I. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>TOWN Bethesda</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) <u>TOWN Bethesda</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.F.D.#3</u>				STREET ADDRESS (If rural, give location) <u>R.F.D.#3</u>			
3. NAME OF DECEASED: (First) <u>Danny</u>		(Middle) <u>Lee</u>		(Last) <u>HILL</u>		4. DATE OF DEATH (Month) <u>January</u> (Day) <u>5</u> (Year) <u>1956</u>	
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>		8. DATE OF BIRTH: <u>6-1-1955</u>	
9. AGE last birthday: yrs. <u>1</u>		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>infant</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>none</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME: <u>Chester A. Hill</u>		14. MOTHER'S MAIDEN NAME: <u>Nancy Doan</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>---</u>		17. INFORMANT & ADDRESS: <u>Father Chester A. Hill - above add.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						24 hours	
<u>49?x</u> Immediate cause (a) <u>Pneumonia</u> DUE TO							
Antecedent cause(s) (b) <u>DUE TO</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County)		21d. (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
SIGNATURE <u>John G. Ball.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>Jan. 5, 1956</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>1-7-1956</u>		NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		LOCATION (City, town, or county) <u>Rockville</u> (State) <u>Md</u>	
DATE REC'D BY LOCAL REG. <u>1/9/56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		FUNERAL DIRECTOR <u>Robert A. Lumshey</u>		ADDRESS <u>Bethesda, Md</u>	



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

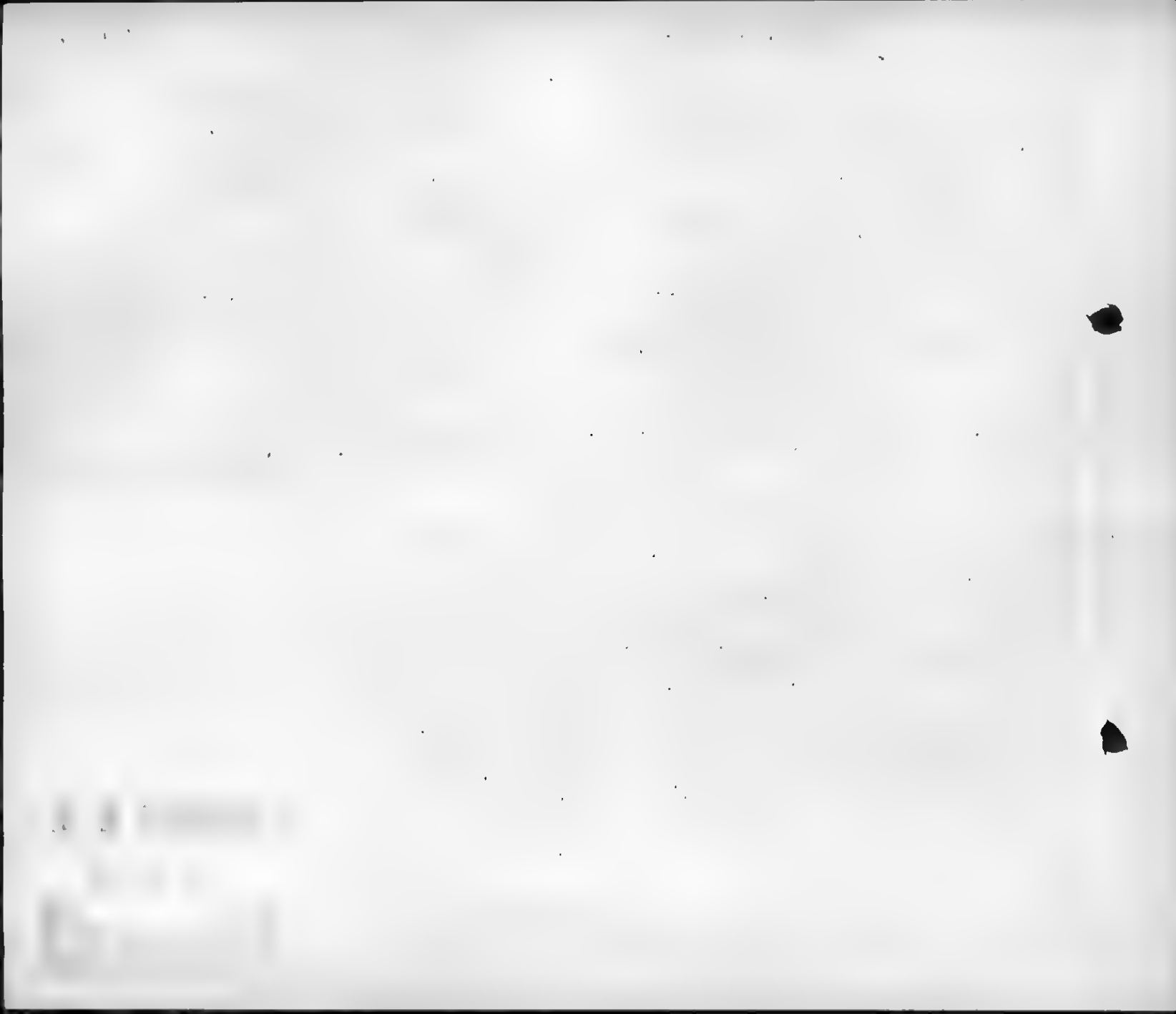
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00765

CERTIFICATE OF DEATH

Reg. Dist. No. 216 ...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>2 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Derwood</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hosp.</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Robert R. Hogston</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>JAN 15 1956</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>June 5</u>	9. AGE last birthday <u>57</u> yrs.	IF UNDER 1 YEAR Months <u>10</u>	IF UNDER 24 HRS. Days <u>10</u>	Hours <u>10</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Plumbers helper</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Plumbers helper</u>		11. BIRTHPLACE (State or foreign country): <u>Smith Co., Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME: <u>Samuel Hogston</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Surber</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Wife - Ethel Hogston</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral anoxia</u>						<u>15 min</u>	
ANTECEDENT CAUSE (B) <u>Cerebral Thrombosis</u>						<u>36 hr</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Hypertension</u>						<u>2 days</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/12</u> , 19 <u>56</u> , to <u>1/15</u> , 19 <u>56</u> that I last saw the deceased alive on <u>1/15</u> , 19 <u>56</u> , and that death occurred at <u>12:10 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Robert R. Hogston</u>		M. D. <u>Robert R. Hogston</u>		ADDRESS <u>1/15/56</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial-Transit</u>		DATE THEREOF <u>1-18-56</u>		NAME OF CEMETERY OR CREMATORY <u>Elizabeth Cemetery</u>		LOCATION (City, town, or county) (State) <u>Smith County, Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/20/56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Robert R. Hogston</u>		ADDRESS <u>Bethesda, Md.</u>	



CERTIFICATE OF DEATH

Reg. Dist. No. 223

719

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
TOWN <u>Takoma Park</u>		<u>D.O.A.</u>		<u>Silver Spring</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Sanitarium and Hospital</u>				STREET ADDRESS (If rural give location) <u>600 Thayer Ave</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Wionel Landon Hood</u>				<u>Jan 16 1956</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>Caucasian</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>Dec 28, 1906</u>	9. AGE last birthday: <u>49</u> yrs.	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Signal Corp U.S. Army civilian employee</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Temple Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>	
13. FATHER'S NAME: <u>Eugene Hood</u>				14. MOTHER'S MAIDEN NAME: <u>Callie De Bord</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO.: <u>455-07-7030</u>		17. INFORMANT & ADDRESS: <u>Mrs. Elean Hood - wife - Sameas deceased.</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Acute Heart Failure</u>						<u>1 hour</u>	
ANTECEDENT CAUSE (S): (B) <u>Acute Coronary Occlusion (Second Episode)</u>						<u>1 hour</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Arteriosclerotic Heart Disease</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 5</u> , 1955, to <u>Jan 16</u> , 1956, that I last saw the deceased alive on <u>1/13</u> , 1956, and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Benjamin Dawson</u>				ADDRESS <u>M.D. 7733 Alaska Ave. N.W. Wash. D.C.</u>		DATE SIGNED <u>1/16/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY): <u>Trans. & Burial</u>		DATE THEREOF <u>1/20/56</u>		NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cemetery</u>		LOCATION (City, town, or county) (State) <u>Temple, Bell County, Texas</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Jan 17-1956</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Warner E. Humphrey</u>		ADDRESS <u>8434 Ga. Ave. Silver Spring, Maryland</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Signed Captain
5.6.700

RECEIVED
JAN 19 1956

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 274

82

1. PLACE OF DEATH:

COUNTY Montgomery MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town) Silver Spring LENGTH OF STAY (in this place) since 1938
 TOWN Silver Spring
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 839 Gist Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md COUNTY Montgomery
 CITY (If outside corporate limits, write RURAL and give nearest town) Silver Spring
 OR TOWN Silver Spring
 STREET ADDRESS (If rural, give location) 839 Gist Ave.

3. NAME OF DECEASED: (First) John (Middle) Joseph (Last) Hurley
 (Type or Print)

4. DATE OF DEATH: (Month) Jan (Day) 17 (Year) 1956

5. SEX: Male 6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed 8. DATE OF BIRTH: May 15, 1890

9. AGE last birthday: 65 YRS. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper - U. S. Patent Office

10b. KIND OF BUSINESS OR INDUSTRY: (Gov't.) Unionville, Conn.

11. BIRTHPLACE (State or foreign country): Unionville, Conn.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME:

John Hurley

14. MOTHER'S MAIDEN NAME:

Maria Sullivan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) yes (If Yes, give war or dates of service) WW #1

16. SOCIAL SECURITY No.: none

17. INFORMANT & ADDRESS: Mrs. Jane Molumphy, 114 N. Main St. West Hartford, Conn.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a) DUE TO Acute Coronary Thrombosis

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO Atherosclerosis

(c) DUE TO Diabetes Mellitus

INTERVAL BETWEEN ONSET AND DEATH Sudden Death

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY Jan 17, 1956 12:15 P.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 17, 1955, to Jan. 16, 1956, that I last saw the deceased alive on Jan. 16, 1956, and that death occurred at 12:15 P.M., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE) ADDRESS

DATE SIGNED

Philip C. Jones M.D. 918 Ellsworth Dr Silver Spring Md
 23. BURIAL, CREMATION REMOVAL (Specify): Burial DATE THEREOF 1/19/56

NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cemetery LOCATION (City, town, or county) Arlington, Virginia (State) Jan 17, 1956

DATE REC'D BY LOCAL REG. 1-20-56

REGISTRAR'S SIGNATURE Francis Potter

24. FUNERAL DIRECTOR Walter E. Pumphrey

ADDRESS Silver Spring, Md.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BOONE & S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00768

CERTIFICATE OF DEATH

Reg. Dist. No. 219

Items 1,12 Film 8191 1-13-56 et

1. PLACE OF DEATH- COUNTY <u>Montgomery</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD.</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> TOWN <u>Germanatown</u>		LENGTH OF STAY (In this place) <u>1 yr</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Germanatown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>12 Maryland Rest Home</u>				STREET ADDRESS (If rural, give location) <u>Germanatown Md</u>	
3. NAME OF DECEASED (Type or Print) <u>Laura</u> (First) <u>Husser</u> (Middle) <u>Husser</u> (Last)		4. DATE OF DEATH <u>1-7-56</u> (Month) <u>7</u> (Day) <u>19</u> (Year)			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Wid</u>	8. DATE OF BIRTH <u>May 21 1878</u>	9. AGE last birthday <u>77</u>	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>W</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Steve Kluge</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Madu</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. (If yes, give war or dates of service)		17. INFORMANT AND ADDRESS <u>Rest Home Records</u>	
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1</u> Immediate cause (a) <u>Coronary occlusion</u> Antecedent cause(s) (b) <u>Coronary sclerosis</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)					INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>3 years</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan 6</u> , 19 <u>56</u> , to <u>Jan 2</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 6</u> , 19 <u>56</u> , and that death occurred at <u>4:20 P.</u> m., from the causes and on the date stated above.					
SIGNATURE <u>Vernon E. Spillers M.D.</u>		(Degree or title)		ADDRESS <u>Germanatown Md</u>	
DATE SIGNED					
23. BURIAL, CREMATION REMOVAL (Specify) <u>11/15/56</u>		DATE THEREOF		NAME OF CEMETERY OR CREMATORY <u>Washington, D.C.</u>	
DATE REC'D BY LOCAL REG. <u>1-9-56</u>		REGISTRAR'S SIGNATURE <u>Laurel H. Budge</u>		24. FUNERAL DIRECTOR <u>W.R. H. ...</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

5732 Ha. Ave. N.W.

See maintenance

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Montgomery</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Montgomery</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Bethesda</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Silver Spring</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Suburban Hospital</i>		STREET ADDRESS (If rural give location) <i>12117 Georgia Avenue</i>	
3. NAME OF DECEASED: (Type or Print) <i>Barnett DeWitt Inocoe, Sr.</i>		4. DATE (Month) (Day) (Year) OF DEATH: <i>1-15-1956</i>	
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH: <i>8-21-92</i>
9. AGE last birthday <i>63</i> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Shoey Clerk</i>		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <i>Virginia</i>
12. CITIZEN OF WHAT COUNTRY? <i>US.</i>		13. FATHER'S NAME: <i>Uriah Inocoe</i>	
14. MOTHER'S MAIDEN NAME: <i>Chrismond, Annette</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <i>yes</i>	
16. SOCIAL SECURITY NO. <i>577-03-1141</i>		17. INFORMANT & ADDRESS: <i>Barnett D. Inocoe, Jr.</i>	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <i>Bronchopneumonia, bilateral</i>		<i>week?</i>	
ANTECEDENT CAUSE (B) <i>metastatic carcinoma liver</i>		<i>8 mos.</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <i>carcinoma tongue</i>		<i>3 1/2 yrs.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Adenoid tumor, bilateral</i>			
19A. DATE OF OPERATION: <i>Nov 1952</i>		19B. MAJOR FINDINGS OF OPERATION: <i>Roscoe (pink) adenoid tumor, tongue</i>	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Dec 26, 1955, to Jan 15, 1956, that I last saw the deceased alive on Jan 15, 1956, and that death occurred at 9:15 P.M., from the causes and on the date stated above.			
SIGNATURE <i>John Lawrence Avery MD.</i>		DATE SIGNED <i>Jan 15 1956</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Jan 19 1956</i>	
NAME OF CEMETERY OR CREMATORY <i>St. Lincoln Cemetery</i>		LOCATION (City, town, or county) <i>Prince George's Co Md</i>	
24. FUNERAL DIRECTOR <i>J. Arthur Walters</i>		ADDRESS <i>254 Carroll St NW Wk</i>	
DATE REC'D BY LOCAL REGISTRAR <i>1/18/56</i>		REGISTRAR'S SIGNATURE <i>Beattie M. Howard</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

U. S. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>6 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Altavista Rest Home</u>				STREET ADDRESS (If rural give location) <u>7802 Maple Ridge Rd.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Julia Jane Jenner</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan 28 1956</u>			
5. SEX: <u>F</u>		6. COLOR OR RACE: <u>Wh</u>		7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>Oct. 17, 1876</u>	
9. AGE last birthday: <u>79</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY: <u>Doctor</u>		11. BIRTHPLACE (State or foreign country): <u>Ballatin Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Doctor, Gen. Practice</u>				13. FATHER'S NAME: <u>Joshua Willis Alexander</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u>				16. SOCIAL SECURITY NO.: <u>None</u>		17. INFORMANT & ADDRESS: <u>Mr. Preston J. Alexander Bethesda, Md.</u>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>491X</u> <u>Broncho pneumonia</u>				<u>72 hrs</u>			
ANTECEDENT CAUSE (B) <u>5 yrs. bed invalidism from</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>sexility + fractured vertebra</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1949</u> to <u>1-28</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1-27</u> , 19 <u>56</u> , and that death occurred at <u>9:20</u> P.M., from the causes and on the date stated above.							
SIGNATURE <u>Wm. M. Ballinger</u>		M. D.		ADDRESS <u>1801 Eye N.W.</u>		DATE SIGNED <u>1-29-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2-1-1956</u>		NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cem</u>		LOCATION (City, town, or county) (State) <u>Prince Georges Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-31-56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>		ADDRESS <u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

И. А. ИВАНОВ

17

1922

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

86
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00771

Reg. Dist.

No. 213

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Clarksville</u>		LENGTH OF STAY (in this place) <u>11 yrs</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Clarksville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rt 1 # 3</u>				STREET ADDRESS (If rural, give location) <u>1270 # 3</u>			
3. NAME OF DECEASED: (First) <u>Ella</u> (Middle) <u>Maie</u> (Last) <u>Johnson</u>				4. DATE OF DEATH (Month) <u>Jan</u> (Day) <u>23</u> (Year) <u>1956</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>Cool</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>Oct 5 1911</u>	
9. AGE last birthday: <u>44</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work, life, even if retired): <u>Housewife</u>		11. BIRTHPLACE (State or foreign country): <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Orson Rudolph</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Virginia Mc Donald - Rockville, MD</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>Hemorrhage</u> DUE TO							<u>20-30 min</u>
Antecedent cause(s) (b) <u>Numerous papule, wounds of ants</u> DUE TO							<u>20-30'</u>
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Shot - gun pellets</u>							<u>20-30'</u>
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Home</u>		21c. (City or town) (County) (State) <u>Clarksville, MD, Montg</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>7:30 PM - 1-23-56 M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Shot by gun barrel</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input checked="" type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
SIGNATURE <u>Frank J. Broschert</u>		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>1-24-56</u>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAM. <input type="checkbox"/>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>1-27-56</u>		NAME OF CEMETERY OR CREMATORY <u>Rocky Hill</u>		LOCATION (City, town, or county) (State) <u>Clarksville, MD</u>	
DATE REC'D BY LOCAL REG. <u>1/25/56</u>		REGISTRAR'S SIGNATURE <u>Laurel H. Bryant</u>		24. FUNERAL DIRECTOR <u>Robert L. Snowden - Rockville, MD</u>		ADDRESS	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

807

00772
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 217

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR TOWN	
X TOWN <u>Rockville (rural)</u>		<u>1 hr</u>		TOWN <u>Rockville (rural)</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Smith Store, Norbeck</u>				STREET ADDRESS (If rural, give location) <u>1270</u>			
3. NAME OF DECEASED: (First) <u>Gilbert</u> (Middle) <u>Johnson</u> (Last) <u>Johnson</u>				4. DATE OF DEATH (Month) <u>Jan</u> (Day) <u>27</u> (Year) <u>1956</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>col</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Divorced</u>		8. DATE OF BIRTH: <u>Mar. 10, 1907</u>	
9. AGE last birthday: <u>48</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>U.S.A</u>	
13. FATHER'S NAME: <u>John Johnson</u>				14. MOTHER'S MAIDEN NAME: <u>Emma Pratt</u>			
15. W. DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>W.W. #2</u>		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Ella Johnson - Newmarket, MD</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>Coronary occlusion</u> DUE TO							<u>Sudden</u>
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							<u>death</u>
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>David J. Byschack</u>		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>1-27-56</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>2-1-56</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		LOCATION (City, town, or county) (State) <u>Arlington Va</u>	
DATE REC'D BY LOCAL REG. <u>1-31-56</u>		REGISTRAR'S SIGNATURE <u>Esther Barber</u>		24. FUNERAL DIRECTOR <u>Robert L. Suorik</u>		ADDRESS <u>Rockville MD</u>	

U.S. AIR FORCE

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—Baltimore, 18 00773
 808 CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u> MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	STATE <u>Washington</u> COUNTY <u>D.C.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>7</u>
OR TOWN <u>Silver Spring</u>	LENGTH OF STAY (in this place) <u>3 1/2 months</u>	OR TOWN	STREET ADDRESS (If rural give location) <u>6713 14th St. N.W.</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>12819 Connecticut Ave.</u>			
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>Mary</u> (Middle) <u>Johnson</u> (Last) <u>Johnson</u>		(Month) <u>Jan</u> (Day) <u>22</u> (Year) <u>19 56</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Widowed</u>	8. DATE OF BIRTH: <u>12/7/69</u>
		9. AGE last birthday: <u>86</u> yrs.	10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY: <u>—</u>	11. BIRTHPLACE (State or foreign country): <u>Sweden</u>	12. CITIZEN OF WHAT COUNTRY: <u>U.S.</u>
13. FATHER'S NAME: <u>Andrew Olson</u>	14. MOTHER'S MARDEN NAME: <u>Unknown</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)	16. SOCIAL SECURITY No: <u>—</u>	17. INFORMANT & ADDRESS: <u>daughter 12819 Conn. Ave. Elsie Seckel</u>	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH.			
Immediate cause		(a) <u>Cerebral vascular accident</u>	Interval Between Onset And Death <u>24 hours</u>
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.		(b) <u>Generalized arteriosclerosis</u>	
(c) <u>Congestive heart failure.</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION: <u>10/29/55</u>		19b. MAJOR FINDINGS OF OPERATION: <u>Deep femoral thrombosis left leg with gangrene</u>	
20. AUTOPSY? <u>No</u>			
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>None</u>		PLACE (Home, farm, factory, street, or office bldg.) <u>None</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>None</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
		HOW DID INJURY OCCUR? <u>None</u>	
22. I hereby certify that I attended the deceased from <u>10/23</u> , 19 <u>55</u> , to <u>1/22</u> , 19 <u>56</u> that I last saw the deceased alive on <u>1/20</u> , 19 <u>56</u> and that death occurred at <u>9:30 AM</u> from the causes and on the date stated above.			
SIGNATURE <u>John B. Unihan</u>		ADDRESS <u>8805 Conn. Ave.</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Transit & Burial</u>		DATE THEREOF <u>1-25-1956</u>	
NAME OF CEMETERY OR CREMATORY <u>Brooklyn New York</u>		LOCATION (City, town, or county) (State) <u>D.C.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-22-1956</u>		REGISTRAR'S SIGNATURE <u>Frances Potter</u>	
24. FUNERAL DIRECTOR <u>S.N. Hines Co.</u>		ADDRESS <u>2901 14th St. N.W. D.C.</u>	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **14 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01193

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Silver Spring (Montgomery)</u> MARYLAND CITY <u>Silver Spring</u> (If outside corporate limits, write RURAL and give nearest town) TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>None</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>Silver Spring (Montgomery)</u> CITY <u>Silver Spring</u> (If outside corporate limits, write RURAL and give nearest town) OR TOWN STREET ADDRESS <u>1923-EAST WEST HIGHWAY, S.S. MD.</u> (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Lucie B. Jones</u> (First) (Middle) (Last)				4. DATE OF DEATH <u>Jan 2</u> 19 <u>56</u> (Month) (Day) (Year)			
5. SEX <u>Fe.</u>	6. COLOR OR RACE <u>Wh.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>APRIL 6, 1874</u>	9. AGE last birthday <u>81</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STORE</u>		11. BIRTHPLACE (State or foreign country) <u>ANNAPOLIS, MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>SAMUEL JONES</u>				14. MOTHER'S MAIDEN NAME <u>JULIANNA THOMPSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-05-9979A</u>		17. INFORMANT & ADDRESS <u>FRANK P. KULP, 1923-EAST WEST HWY. (NEPHEW)</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>						<u>2 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Congestive Heart Failure</u>						<u>2 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Arteriosclerotic Heart Disease</u>						<u>Unknown</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION <u>None</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>None</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>None</u>			
22. I hereby certify that I attended the deceased from <u>Jan 2</u> , 19 <u>56</u> to <u>Jan 2</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 1</u> , 19 <u>56</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James M. Loftis</u>		M.D. <u>1673-Bark Road - Wash. D.C.</u>		DATE SIGNED <u>Jan 2 56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>1/4/56</u>		NAME OF CEMETERY OR CREMATORY <u>St. Anne's</u>		LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
24. REC'D BY REGISTRAR <u>Jan 3, 1956</u>		REGISTRAR'S SIGNATURE <u>Frances Potter</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>James M. Loftis</u> ADDRESS <u>Annapolis, Md.</u>			

U.S.

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CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write and give nearest town) <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>16 days</u>		CITY (If outside corporate limits, write and give nearest town) <u>5209 Acacia Ave.</u>		OR TOWN <u>Bethesda</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hosp.</u>				STREET ADDRESS (If rural give location) <u>Bethesda</u>			
3. NAME OF DECEASED: (Type or Print) <u>Robert Almon</u> (First) <u>JULIA</u> (Middle) <u>(JR)</u> (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <u>1</u> <u>19</u> <u>1956</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Feb. 12, 1886</u>	9. AGE last birthday: <u>69</u> yrs.	IF UNDER 1 YEAR: Months <u>11</u> Days <u>7</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Real Estate Broker</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>New York State</u>	
12. FATHER'S NAME: <u>Robert Almon Julia Sr.</u>				13. MOTHER'S MARRIAGE NAME: <u>Ella Urania Baker</u>			
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service)				15. SOCIAL SECURITY NO.: <u>UNKNOWN</u>		16. INFORMANT & ADDRESS: <u>Wife - Virginia S. Julia - above</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>Acute Pulmonary Edema</u>	DUE TO	
ANTECEDENT CAUSE (B) <u>Rt. Cardiovascular Incident with right hemiplegia</u>	DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(C) <u>Benign Prostatic Hypertrophy</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION: <u>2</u>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/3, 1956, to 1/19, 1956, that I last saw the deceased alive on 1/18, 1956, and that death occurred at 9:54 M., from the causes and on the date stated above.

SIGNATURE J. L. Markham ADDRESS 6306 Wisconsin Ave DATE SIGNED 1/19/56

23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>	DATE THEREOF <u>1/20/1956</u>	NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	LOCATION (City, town, or county) (State) <u>Prince George Maryland</u>
DATE REC'D BY LOCAL REGISTRAR <u>1/20/56</u>	REGISTRAR'S SIGNATURE <u>Bennie M. Thompson</u>	24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>	ADDRESS <u>Bethesda, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

COUNTY Montgomery MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town) Takoma Park
 OR TOWN
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Eventide Rest Home
700 Hudson Ave

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Montgomery
 CITY (If outside corporate limits, write RURAL and give nearest town) Silver Spring
 OR TOWN
 STREET ADDRESS (If rural give location) 9409 New Hampshire Rd

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

HectorBKeener

4. DATE OF DEATH:

(Month)

(Day)

(Year)

1321956

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR IF UNDER 24 HRS.

MWWidowedSept-16-187877 yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired:

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY:

FarmerNoneVa.USA

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

Walker KeenerMary Pangle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

noRobert L. Keener (Son)1628 Eutam Rd
Baltimore, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

Broncho-pneumonia bilateral

Interval Between Onset And Death

4 days

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO Primary Carcinoma of Prostatemultiple metastases to abdominal viscera and lymph nodesArterial embolism, left femoral artery1 1/2 years2 months

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Arteriosclerosis, generalizedUndetermined

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Dec 4, 1954Carcinoma of Prostate, multiple metastasesYes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 2, 1954 to Jan 22, 1956, that I last saw the deceasedalive on Jan 21, 1956, and that death occurred at 11:00 AM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Jan 22-1956J. Wilson DoddS.H. Hines Co, 2901 14th St NWWASH. D.C.

В. А. ПУХОВ

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ОБМЕН

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda</u>	LENGTH OF STAY (in this place) <u>26 hours</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hosp.</u>		STREET ADDRESS (If rural give location) <u>9721 Montauk Ave.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Inna Baptista Kelly</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan 3 1956</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOWED</u>	8. DATE OF BIRTH: <u>Feb. 10, 1875</u>
9. AGE last birthday <u>80</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>James Stanton</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Galligan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT'S ADDRESS: <u>Mrs. R.E. Cavanaugh - daughter</u>		Item # 2	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>			<u>26 days</u>
ANTECEDENT CAUSE (B) <u>Congestive Heart Failure</u>			<u>4 years</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec. 17, 1955</u> , to <u>Jan. 3, 1956</u> , that I last saw the deceased alive on <u>Jan. 3, 1956</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>J. R. Kelly M.D.</u>		ADDRESS <u>M.D. 3701 Leland St. Ch. Ch. Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial-Transit</u>		DATE-THEREOF <u>1-4-56</u>	
NAME OF CEMETERY OR CREMATORY <u>St. Josephs</u>		LOCATION (City, town, or county) (State) <u>Chickasaw Co., Iowa</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/4/56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	
FUNERAL DIRECTOR <u>Robert M. Thompson</u>		ADDRESS <u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PHOTOGRAPH

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CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Montgomery	MARYLAND	STATE Virginia	COUNTY Alexandria
CITY (If outside corporate limits, write RURAL OR and give nearest town) Bethesda Rural	LENGTH OF STAY (in this place) 1 Mo 15da	CITY (If outside corporate limits, write RURAL and give nearest town) Sherman	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital		STREET ADDRESS (If rural give location) 3203 Old Dominion Blvd.	
3. NAME OF DECEASED: (First) William (Middle) Talty (Last) KENNY		4. DATE (Month) (Day) (Year) OF DEATH: Jan 20 1956	
5. SEX: M	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 2-17-05
9. AGE last birthday: 50 yrs.		IF UNDER 1 YEAR: Months 11 Days	IF UNDER 24 HRS.: Hours 11 Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mariner		10B. KIND OF BUSINESS OR INDUSTRY: U.S. NAVY	
11. BIRTHPLACE (State or foreign country): Tenn.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME: John M. KENNY		14. MOTHER'S MAIDEN NAME: Katherine TALTY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unk.) Yes (If Yes, give war or dates of service) WWII Korea		16. SOCIAL SECURITY NO. -----	
17. INFORMANT & ADDRESS: W: Josephine C. KENNY			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Thrombosis, Renal artery		2 days	
ANTECEDENT CAUSE (B) Thrombosis, Aorta, abdominal		+ 1 month	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Arteriosclerosis			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Pulmonary edema Hypertension, arterial		8 hours - 6-7 years	
19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) INJURY OCCUR?	(County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 12-5-55 , to 1-20 , 19 56 , that I last saw the deceased alive on 1-20 , 19 56 , and that death occurred at 8A M, from the causes and on the date stated above.			
SIGNATURE Bl. CANAGA CAPT MC		ADDRESS USN U. S. Naval Hospital, NNHC, Bethesda, Maryland	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 1-24-56	
NAME OF CEMETERY OR CREMATORY Arlington National		LOCATION (City, town, or county) (State) Arlington Va.	
DATE REC'D 20-1-56 REGISTRAR		REGISTRAR'S SIGNATURE Wm. P. Savelly	
24. FUNERAL DIRECTOR R.A. PUMPHREY		ADDRESS Funeral Home 7557 Wisconsin Avenue, Bethesda, Maryland	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5 1/2 070105

JAN 1955

151

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

813

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00778

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Olney</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Gaithersburg</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Montgomery County Gen. Hosp</u>				STREET ADDRESS (If rural give location) <u>Summit Hall Turf Farm</u>			
3. NAME OF DECEASED. (First) <u>Lona</u> (Middle) <u>Miller</u> (Last) <u>Keplinger</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>1</u> <u>27</u> <u>1956</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>80</u> yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Louis F. Miller</u>				14. MOTHER'S MAIDEN NAME: <u>Frances Hilligoss</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Hospital Records</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Adenocarcinoma of Thyroid</u>						<u>5 months</u>	
ANTECEDENT CAUSE (B) <u>Gland</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>Nov. 1955</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Carcinoma of Thyroid</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 3, 1956</u> , to <u>Jan. 27, 1956</u> , that I last saw the deceased alive on <u>Jan. 27, 1956</u> , and that death occurred at <u>2:55</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>Jack Schumacher</u>		ADDRESS <u>Baltimore, Md.</u>		DATE SIGNED <u>Jan. 27, '56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 30, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Rockville Union Cemetery</u>		LOCATION (City, town, or county) (State) <u>Rockville Md. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-28-56</u>		REGISTRAR'S SIGNATURE <u>Gertrude B. Lawley</u>		24. FUNERAL DIRECTOR <u>S. C. Pumpfroy</u>		ADDRESS <u>7557 W. Ave. Beth. Md.</u>	

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

81

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00779

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u> MARYLAND		CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Bethesda</u>		STATE <u>MD.</u> COUNTY <u>Mont.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hosp.</u>		LENGTH OF STAY (in this place) <u>1 day</u>		STREET ADDRESS (If rural give location) <u>Rt. 1, Bel Pre Road</u>			
3. NAME OF DECEASED: (Type or Print) <u>Barbara Emeline King</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan 4, 1956</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>		8. DATE OF BIRTH: <u>Dec. 5, 1929</u>	
9. AGE last birthday <u>26</u> yrs.		10. MONTHS <u>26</u>		11. DAYS <u>26</u>		12. HOURS <u>26</u> Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Raymond Milton Clark</u>				14. MOTHER'S MAIDEN NAME: <u>Marguerite Turner</u>			
15. WAS DECEASED EVER IN U.S. ARMY OR NAVY (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No. <u>4-4-4-4-4-4</u>		17. INFORMANT & ADDRESS: <u>Herman King - husband</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE				(A) <u>Adenocarcinoma, Metastatic,</u> <u>1 yr.</u>			
ANTECEDENT CAUSE (B)				(B) <u>Liver, Lungs.</u> <u>1 yr.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(C) <u>Adenocarcinoma, Rectum</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Portal obstruction due to Hepatomegaly -</u>							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 15, 1955</u> , to <u>Jan. 3, 1956</u> , that I last saw the deceased alive on <u>Jan. 3</u> , 1956, and that death occurred at <u>7:50 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Arthur S. Norton</u>		M. D. <u>Bethesda Md</u>		DATE SIGNED <u>1/4/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan 7, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Coleville Cemetery</u>		LOCATION (City, town, or county) (State) <u>Coleville Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/4/56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Thomas E. Thompson</u>		ADDRESS <u>8/30/ Georgia Ave</u>	

U.S. DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY
WASHINGTON, D. C.

815

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH.				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <u>Rural Brookmont</u>				OR TOWN <u>Rural Brookmont</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>RFD Bethesda</u>				STREET ADDRESS (If rural give location) <u>RFD Bethesda</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH: (Month) (Day) (Year)			
(First) <u>James</u> (Middle) <u>Herbert</u> (Last) <u>KING</u>				OF DEATH: <u>January 3</u> <u>1956</u>			
5. SEX.	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>Jan. 11-1880</u>	<u>75</u> yrs.	<u>11</u> Months <u>22</u> Days	<u>11</u> Hours <u>22</u> Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>Ret. Canal Lockkeeper</u>				<u>C & O RR</u>		<u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME: <u>Benj. F. King</u>			
14. MOTHER'S MAIDEN NAME: <u>Harriet Frances Sullivan</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>none</u>				17. INFORMANT & ADDRESS: <u>Julia King, sister-in-law -6100 Ridge Dr. Wash 16, D.C.</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>							<u>Sudden</u>
ANTECEDENT CAUSE (B) <u>Arteriosclerosis of Heart</u>							<u>3 YEARS</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C) <u>Bronchopneumonia</u>							<u>7 DAYS</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 6, 1950</u> , to <u>Jan 3, 1956</u> , that I last saw the deceased alive on <u>Dec 29, 1955</u> , and that death occurred at <u>0:20 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Dr. A. G. Smith</u>				DATE SIGNED <u>1-4-56</u>			
ADDRESS <u>M. D. 5009 DelRay Ave. Beth. Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1-6-1956</u>		<u>Walkers Chapel</u>		<u>Arlington Va.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/4/56</u>		REGISTRAR'S SIGNATURE <u>Benjamin M. Thompson</u>		24. FUNERAL DIRECTOR <u>W. A. Pumphrey</u>		ADDRESS <u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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816

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

COUNTY Montgomery MARYLAND
 CITY (If outside corporate limits, write RURAL LENGTH OF STREET OR and give nearest town) Wheaton City 3 mos.
 TOWN R.F.D. Rockville Silver Spring
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 12818 Parkland Dr.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Mont.
 CITY (If outside corporate limit write RURAL and give nearest town) Rockville (Wheaton City)
 TOWN R.F.D. Rockville Silver Spring
 STREET ADDRESS 12818 Parkland Dr.

3. NAME OF DECEASED:

(First) Marilyn (Middle) Jeanette (Last) Klee
 (Type or Print)

4. DATE OF DEATH: (Month) 1 (Day) 1 (Year) 1956

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 9-28-55

9. AGE last birthday: If UNDER 1 YEAR If UNDER 24 HRS.
 yrs. 3 Months 4 Days 4 Hours 4 Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: none

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William Walter Klee

14. MOTHER'S MAIDEN NAME: Winifred Quinn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO: none

17. INFORMANT & ADDRESS: W. W. Klee, 12818 Parkland Dr., Rockville, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

493X
 Immediate cause

(a) Pneumonia
 DUE TO

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)
 DUE TO

(c)

Interval Between Onset And Death
22 hrs.

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Mongolian Idiocy

19a. DATE OF OPERATION: 0

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-31, 1955, to 1-1, 1956, that I last saw the deceased

alive on 12-31, 1955, and that death occurred at 5:30 AM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

Burial

1/3/56

St. John's Cemetery

Silver Spring, Maryland

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Jan 3/56

Frances C. Miller

Warner E. Humphrey

8434 Ga. Ave. Silver Spring, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

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817
CERTIFICATE OF DEATH

Item 14, Film 91 1-23-56 et

Reg. Dist. No. 214

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY MONTGOMERY MARYLAND		STATE md COUNTY Montg		CITY (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		CITY (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
TOWN		LENGTH OF STAY (in this place)		TOWN		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 17 Hilltop Rd.				17 Hilltop Rd.			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) DEBORAH LOUIS KNOBLOCK				4. DATE OF DEATH (Month) (Day) (Year) JAN 16 1956			
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) child	8. DATE OF BIRTH DEC 20 1955	9. AGE last birthday yrs. 26		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PHILADELPHIA PA		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME SAUL KNOBLOCK				14. MOTHER'S MAIDEN NAME MARTHA Polusky			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS SAUL KNOBLOCK 17 HILLTOP RD.		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) Congenital Heart Disease							
ANTECEDENT CAUSE(S) DUE TO Prematurity							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 12, 1956, to Jan 16, 1956, that I last saw the deceased alive on Jan 16, 1956, and that death occurred at 3:25 P.M. from the causes and on the date stated above.							
SIGNATURE Joseph Rose				DATE SIGNED ADDRESS (Street, city, town, state) M.D. 4829-16 St. N.W., Wash D.C. 1-16-56			
23. BURIAL, CREMATION, REMOVAL, etc.		DATE THEREOF 1-16-56		NAME OF CEMETERY OR CREMATORY George Washington Memorial		LOCATION (City, town or county) (State) Hyattsville Md	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Frances Carter		25. FUNERAL DIRECTOR'S SIGNATURE Goldberg Funeral Home		ADDRESS Wash D.C.	
DATE 1-19-56							

INSTRUCTIONS

1
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

Reg. Dist. No. ...

423

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		LENGTH OF STAY (in this place) <u>5 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Glen Burnie</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington San and Hospital</u>				STREET ADDRESS (If rural give location) <u>101 M St. S.E.</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year) OF DEATH:			
(First) <u>Mary</u> (Middle) <u>Newton</u> (Last) <u>Kreider</u>				January 16 1956			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>Oct. 12, 1884</u>	
9. AGE last birthday: <u>71</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Own home</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME: <u>Unknown - Ballman</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no or unk.): <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.: <u>None</u>		17. INFORMANT & ADDRESS: <u>Chart - Mr Charles Kreider (same)</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						13 hrs	
ANTECEDENT CAUSE (B) <u>Essential hypertension</u>						Many yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 11, 1956</u> , to <u>Jan 16, 1956</u> , that I last saw the deceased alive on <u>Jan 15, 1956</u> , and that death occurred at <u>7:05 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Raymond O. West</u>				ADDRESS <u>M. D. Takomas Jk.</u>		DATE SIGNED <u>Jan 16/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY): <u>Burial</u>		DATE THEREOF: <u>January 18/56</u>		NAME OF CEMETERY OR CREMATORY: <u>Glen Haven</u>		LOCATION (City, town, or county) (State): <u>Glen Burnie, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR: <u>JAN-18-1956</u>		REGISTRAR'S SIGNATURE: <u>L. J. Stach</u>		24. FUNERAL DIRECTOR: <u>W. J. Singleton</u>		ADDRESS: <u>Glen Burnie, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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RECEIVED

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Item 6 Film 192 1-31-56 et

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write and give nearest town)		OR	
TOWN <u>TANAMA PARK, MD</u>		<u>17 days</u>		TOWN <u>Greenleaf, Ind.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington San + Hosp.</u>				STREET ADDRESS (If rural give location) <u>3806 Greenleaf St.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Mrs. Lily LACHO</u>				<u>7 JAN 24 1956</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOWED</u>		8. DATE OF BIRTH: <u>12-21-98</u>	
9. AGE last birthday <u>57</u> yrs.		10. AGE UNDER 1 YEAR		11. AGE UNDER 24 HRS.		12. CITIZEN OF WHAT COUNTRY?	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u>	
13. FATHER'S NAME: <u>JOSEPH LEED</u>				14. MOTHER'S MAIDEN NAME: <u>FREDA</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS: <u>MRS SALMA BRODSKY - same address</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Myocardial Infarction</u>						<u>1-24h</u>	
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Pleural effusion & Compression of Lungs</u>							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While at work Not while at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 7</u> , 19 <u>56</u> , to <u>Jan 24</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 24</u> , 19 <u>56</u> , and that death occurred at <u>6:00</u> P. M. from the causes and on the date stated above.							
SIGNATURE <u>Raymond C. West</u>		M. D. <u>Takoma Park</u>		ADDRESS <u>7600 Conner Ave</u>		DATE SIGNED <u>Jan 24/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1/24/56</u>		<u>Beth Shalom Bern</u>		<u>Hillside Md.</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS			
<u>Jan 25 1956</u>		<u>J. Wilson</u>		<u>B. Danyansky & Son Wash DC</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	LENGTH OF STAY (in this place) <u>5 months</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	TOWN <u>Silver Spring</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>	STREET ADDRESS (If rural give location) <u>1634 Brisbane St.</u>		
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>Alaine</u>	(Middle) <u>F</u>	(Last) <u>Lavoie</u>	(Month) <u>Jan</u> (Day) <u>22</u> (Year) <u>1956</u>
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>FEB. 24, 1899</u>
9. AGE last birthday <u>56</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Beautician</u>	
11. BIRTHPLACE (State or foreign country): <u>ST. HONORE, CHENLEY, CANADA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>GUSTAVE PELLETIER</u>		14. MOTHER'S MAIDEN NAME: <u>MARIE BEAUDOIN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>003-14-5141</u>	
17. INFORMANT & ADDRESS: <u>MRS. ALICE F. HEBERT, 1634 BRISBANE ST., SS., MD.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>			<u>5-6 hrs</u>
ANTECEDENT CAUSE (B) <u>Hypertension</u>			<u>?</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1952 to 22 Jan, 1956</u> that I last saw the deceased alive on <u>17 Jan, 1956</u> , and that death occurred at <u>1255A</u> M, from the causes and on the date stated above.			
SIGNATURE <u>William D. Aud</u>		DATE SIGNED <u>1/22/56</u>	
ADDRESS <u>9006 Wilmers Rd, Sd Spr.</u>			
M. D. <u>9006 Wilmers Rd, Sd Spr.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>SHIP. & BURIAL</u>		24. FUNERAL DIRECTOR <u>Wm. E. Humphrey</u>	
DATE THEREOF <u>JAN. 22, 1956</u>		LOCATION (City, town, or county) (State) <u>LEWISTON, MAINE</u>	
NAME OF CEMETERY OR CREMATORY <u>ST. PETER'S CEMETERY</u>			
SHIP. & BURIAL <u>SHIP. & BURIAL</u>			
DATE REC'D BY LOCAL REGISTRAR <u>1/23/56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	
		ADDRESS <u>SILVER SPRING, MD.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

723

CERTIFICATE OF DEATH

Reg. Dist. No. 223-00786

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington San & Hosp</u>				STREET ADDRESS (If rural give location) <u>Cashell Road</u>			
3. NAME OF DECEASED: (First) <u>BABY</u> (Middle) <u>GIRL</u> (Last) <u>LAYTON</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan. 30</u> <u>1956</u>					
5. SEX: <u>fe</u>	6. COLOR OR RACE: <u>cauc</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>Jan. 30, 1956</u>	9. AGE last birthday: <u>10</u> yrs.	IF UNDER 1 YEAR: Months <u>10</u> Days <u>5</u>	IF UNDER 24 HRS. Hours <u>10</u> Min. <u>5</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Walter Adonis Layton</u>				14. MOTHER'S MAIDEN NAME: <u>Madge Evelyn Huntley</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.): (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS:			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>PREMATURITY</u>							
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 30, 1956</u> , to <u>Jan 30, 1956</u> that I last saw the deceased alive on <u>Jan 30</u> , 1956, and that death occurred at <u>5:10 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>George R. France</u>		ADDRESS <u>927 Pershing Dr. S.E. Wash. D.C.</u>		DATE SIGNED <u>1/31/56</u>			
23. BURIAL CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		DATE THEREOF <u>2-6-56</u>		NAME OF CEMETERY OR CREMATORY <u>Washington San. & Hospital</u>		LOCATION (City, town, or county) (State) <u>Takoma Park 12, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Feb 8-1956</u>		REGISTRAR'S SIGNATURE <u>J. Peter Dohd</u>		24. FUNERAL DIRECTOR <u>R.A. Hare, M.D.</u>		ADDRESS <u>Wash. San. & Hosp. Takoma</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 215

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Rockville</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Rockville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1715 Crawford Drive</u>		STREET ADDRESS (If rural, give location) <u>1715 Crawford Drive</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>LAWRENCE LVAN LLACOCK</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 5, 19 56</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>Oct. 20, 1955</u>
9. AGE last birthday: <u>2</u> yrs. <u>2</u> months <u>15</u> days <u>15</u> hours <u>15</u> min.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Infant</u>	
10b. KIND OF BUSINESS OR INDUSTRY: <u>Infant</u>		11. BIRTHPLACE (State or foreign country): <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>		13. FATHER'S NAME: <u>John Leacock</u>	
14. MOTHER'S MAIDEN NAME: <u>Alice Digley</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)	
16. SOCIAL SECURITY No.: <u>None</u>		17. INFORMANT & ADDRESS: <u>John Leacock-Item # 2</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		15. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>ANOXIA</u>			<u>30 MIN.</u>
Antecedent cause(s) (b) <u>OBSTRUCTION OF RESPIRATORY TRACT</u>			<u>50 MIN.</u>
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Mucopurulent material from upper respiratory infection</u>			<u>2-6 hours</u>
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			

19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .				
SIGNATURE <u>John S. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>1/5/56</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/>		
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>1-7-56</u>	NAME OF CEMETERY OR CREMATORY <u>St. Marys</u>	LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>
DATE REC'D BY LOCAL REG. <u>1/6/56</u>		REGISTRAR'S SIGNATURE <u>Laurel H. Grayson</u> FUNERAL DIRECTOR <u>Robert H. Humphrey</u> ADDRESS <u>Bethesda, Md.</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53



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CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>D.C.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town.) <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>60 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center Nat'l Inst. of Health</u>				STREET ADDRESS (If rural give location) <u>1460 Eastern Ave. N. E.</u>			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(First) <u>Mack</u>		(Middle) <u>- -</u>		(Last) <u>Lee</u>		OF DEATH: <u>January 13, 1956</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>Negro</u>	<u>Married</u>	<u>January 18, 1895</u>	<u>60</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Laborer</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>District Govt.</u>		11. BIRTHPLACE (State or foreign country): <u>Missouri</u>	
13. FATHER'S NAME: <u>Jap Lee</u>				14. MOTHER'S MAIDEN NAME: <u>Cellia Payne</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>yes</u> <u>Unknown</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>THE medical record, The Clinical Center</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cancer of the Liver</u>							
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cor Pulmonale</u>							
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>None</u>		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>None</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov 14, 1955, to Jan 13, 1956, that I last saw the deceased alive on Jan 13, 1956, and that death occurred at 10:15 P.M. from the causes and on the date stated above.							
SIGNATURE <u>Ted Clemens Jr.</u>				ADDRESS <u>The Clinical Center Nat'l Inst. of Health</u>		DATE SIGNED <u>1/14/56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1-18-56</u>		<u>Arlington Mt.</u>		<u>Arlington Va</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-16-56</u>		REGISTRAR'S SIGNATURE <u>Bernie M. Thompson</u>		24. FUNERAL DIRECTOR <u>John T. Stewart</u>		ADDRESS <u>304 H St. N.E.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ROBERT V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

825

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00789

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>	OR TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location) <u>700 Roeder Rd</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>George</u>	(Middle) <u>Leburn</u>	(Month) <u>Jan.</u>	(Day) <u>5</u>
(Type or Print)	(Last) <u>Leese</u>	(Year) <u>1956</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Jan 8 - 1884</u>
9. AGE last birthday: <u>71</u> yrs.	10. MONTHS <u>11</u>	11. DAYS <u>26</u>	12. HOURS <u>0</u> MIN.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Putnam Power Co</u>	
11. BIRTHPLACE (State or foreign country): <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>H. Watson Leese</u>		14. MOTHER'S MAIDEN NAME: <u>Jimmie C. Luckett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>None</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Laura E. Leese</u>		<u>700 Roeder Rd Silver Springs</u>	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			Interval Between Onset And Death
Immediate cause (a) <u>Coronary Thrombosis</u>			<u>12 hrs.</u>
Antecedent causes (s) (b) <u>Arteriosclerosis</u>			<u>10 yrs.</u>
(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Angina Pectoris</u>			<u>15 yrs.</u>
19a. DATE OF OPERATION: <u>None</u>			19b. MAJOR FINDINGS OF OPERATION
21. ACCIDENT SUICIDE HOMICIDE (Specify)			PLACE (Home, farm, factory, street, office bldg., etc.)
(CITY OR TOWN)			(COUNTY)
(STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>None</u> m.			INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March</u> , 19 <u>55</u> , to <u>4 January</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1-4</u> , 19 <u>56</u> , and that death occurred at <u>home</u> <u>1-5-56</u> from the causes and on the date stated above.			
SIGNATURE (Degree or title) <u>Francis I. Coleman M.D.</u>		ADDRESS <u>5315 - 16th St N.W.</u>	
DATE SIGNED <u>1-5-56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Rural</u>		DATE THEREOF <u>Jan. 9-56</u>	
NAME OF CEMETERY OR CREMATORY <u>Shenwood</u>		LOCATION (City, town, or county) (State) <u>Wash. D.C.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-6-56</u>		REGISTRAR'S SIGNATURE <u>Francis I. Coleman</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>H. Hines Co 2901 - 14th St N.W.</u>	

5. 2. 1910

10. 10. 1910

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00790

821

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>1</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<u>Bethesda Rural</u>		<u>12 days</u>		<u>Takoma Park</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>				STREET ADDRESS (If rural give location) <u>7122 Sycamore Avenue</u>			
3. NAME OF DECEASED: (Type or Print)		(First)		(Middle)		(Last)	
<u>Susan</u>		<u>Ann</u>		<u>LEONARD</u>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH:	
<u>Female</u>		<u>White</u>		<u>Single</u>		<u>1-7-56</u>	
9. AGE last birthday				IF UNDER 1 YEAR		IF UNDER 24 HRS.	
				Months		Days	
						Hours	
						Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>None</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>None</u>		11. BIRTHPLACE (State or foreign country): <u>Bethesda, Maryland</u>	
13. FATHER'S NAME: <u>Thomas E. LEONARD</u>				14. MOTHER'S MAIDEN NAME: <u>Helen UNSOELD</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>				16. SOCIAL SECURITY NO. <u>-C-</u>		17. INFORMANT & ADDRESS: <u>Father Thomas E. LEONARD</u> <u>Same As above</u>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) DUE TO <u>Pneumonia, Aspiration</u>				<u>3 hrs.</u>			
ANTECEDENT CAUSE (B) DUE TO <u>Prematurity</u>				<u>16 days</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Malnutrition</u>				<u>11 days</u>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>23 Jan., 1956</u> , to <u>23 Jan, 1956</u> , that I last saw the deceased alive on <u>23 Jan., 1956</u> and that death occurred at <u>12:55A</u> , from the causes and on the date stated above.							
SIGNATURE <u>W. S. Matthews, M.D.</u>				ADDRESS <u>Baltimore National Cemetery, Baltimore, Maryland</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>25 Jan 1956</u>		<u>Baltimore National Cemetery</u>		<u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>23 Jan 1956</u>		<u>Mary E. Casselby</u>		<u>Fialkowski Funeral Home</u>		<u>2007 Eastern Ave, Baltimore, Md.</u>	

U.S. A. C.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00791

822

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>MONTGOMERY</u>		STATE <u>MARYLAND</u>		STATE <u>DC</u>		COUNTY <u>47</u>	
CITY (If outside corporate limits, write RURAL or give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>BETHESDA</u>				TOWN <u>WASHINGTON, DC</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5020 PARK PLACE</u>				STREET ADDRESS <u>6919-6th ST NW</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>IDA</u> (First) (Middle) (Last)				<u>LERNER</u> <u>JAN. 29-1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
<u>F</u>	<u>Wh.</u>	<u>MARRIED</u>	<u>JAN-24-1885</u>	<u>71</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
<u>HOUSEWIFE</u>		<u>-</u>		<u>RUSSIA</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>SOLOMON J. GOLDBERG</u>				<u>ROSE -</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>		<u>507-18-1911</u>		<u>SAMUEL H. LERNER</u> <u>5020 PARK PL. Bethesda, Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
1. IMMEDIATE CAUSE (A)						INTERVAL BETWEEN ONSET AND DEATH	
<u>Carcinoma of the gall-bladder</u>						<u>6 mo.</u>	
2. ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST.							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
<u>Arteriosclerosis, generalized</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
<u>October 3, 1955</u>		<u>Cancer of gall bladder - metastases to liver</u>					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>December 19, 1955</u>, to <u>Jan. 29</u>, 19<u>56</u>, that I last saw the deceased alive on <u>Jan. 28</u>, 19<u>56</u>, and that death occurred at <u>9:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Elaine W. Murphy M.D.</u>				ADDRESS (Street, city, town, state) <u>4812 Ellicott St NW, Washington DC</u>		DATE SIGNED <u>1-29-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>1/31/56</u>		<u>GEO. WASH. MEM. CEM.</u>		<u>HYATTSVILLE, MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>1-31-56</u>		<u>Bessie M. Thompson</u>		<u>Speckberg Funeral Home</u>		<u>4217-9th NW</u>	



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CERTIFICATE OF DEATH

Reg. Dist. No. 216

823

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Mont</i>		MARYLAND		STATE <i>D.C.</i> COUNTY <i>Wash.</i>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Washington D.C.</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Suburban Hospital</i>				STREET ADDRESS (If rural give location) <i>4300 Longman NW</i>			
3. NAME OF DECEASED: (First) <i>Jacob</i> (Middle) <i>Litman</i> (Last) <i>Litman</i>				4. DATE OF DEATH: (Month) <i>Jan.</i> (Day) <i>3</i> (Year) <i>1956</i>			
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>	8. DATE OF BIRTH: <i>Unknown</i>	9. AGE last birthday: <i>77</i> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Teacher</i>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <i>Russia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME: <i>Mordecai Litman</i>				14. MOTHER'S MAIDEN NAME: <i>Rebecca ?</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <i>Alfred Litman</i>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE	(A) <i>Broncho pneumonia</i>	<i>10 DAYS</i>
ANTECEDENT CAUSE (S)	DUE TO (B) <i>Cerebral Hemorrhage</i>	<i>17 DAYS</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (C) <i>Carcinomatous, generalized</i>	<i>6 MONTHS</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Arteriosclerotic Heart Disease</i>		<i>18 MONTHS</i>

19A. DATE OF OPERATION: <i>AUG. 24, 1954</i>	19B. MAJOR FINDINGS OF OPERATION: <i>CARCINOMA, COLON.</i>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<i>OCT. 15, 1954</i>	<i>HYPERNEPHROMA, RIGHT KIDNEY</i>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	21C. WHERE DID (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from *JULY 9, 1951.*, to *JAN 3, 1956*, that I last saw the deceased alive on *JAN. 2, 1956*, and that death occurred at *8:30 A.M.* from the causes and on the date stated above.

SIGNATURE <i>Robert P. George M.D.</i>		ADDRESS <i>M.D. 5009 DEL Ray Ave. Bethesda, Md.</i>		DATE SIGNED <i>1/3/56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	DATE THEREOF <i>1/5/56</i>	NAME OF CEMETERY OR CREMATORY <i>Adas Israel Cemetery</i>	LOCATION (City, town, or county) <i>Wash. D.C.</i>	(State)	
DATE REC'D BY LOCAL REGISTRAR <i>1/3/56</i>	REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i>	24. FUNERAL DIRECTOR <i>B. H. Gausky & Son</i>	ADDRESS <i>Wash. D.C.</i>		

MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 5 1900

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

824				00793			
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18							
MEDICAL EXAMINER'S CERTIFICATE OF DEATH							
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY		Montgomery		STATE		Colorado	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		TOWN		CITY (If outside corporate limits write RURAL and give nearest town)		TOWN	
		Silver Spring				Evans	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
9505 North Avenue				515 Boulder Street			
3. NAME OF DECEASED:		(First)		(Middle)		(Last)	
(Type or Print)		Myrtle		Irene		Luben	
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
Female		White		Single		6/9/02	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		9. AGE last birthday:		4. DATE OF DEATH	
none (semi-invalid)				53 yrs.		Jan. 25 19 56	
11. BIRTHPLACE (State or foreign country):				12. CITIZEN OF WHAT COUNTRY?			
Terre Haute, Indiana				U.S.A.			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Edward Luben				Louise Kohlenberg			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.):				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
no				none		Mrs. Ethel L. Oliver, 9505 North Ave. Silver Spring, Md.	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) Coronary occlusion						Sudden	
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)						Blunt	
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				20. AUTOPSY?			
				Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				21b. PLACE (Home, farm, factory, street, office bldg., etc., OF INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Frank E. Busch		1/30/56		Evans Cemetery		Evans, Colorado	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR	
Trans. & Burial		1-26-56		Frances Potter		Wanner & Humphrey, 8434 Ga. Ave. Silver Spring, Md.	



CERTIFICATE OF DEATH

Reg. Dist. No. 216...

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda</u>	LENGTH OF STAY (in this place) <u>4 1/2 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hosp.</u>		STREET ADDRESS (If rural give location) <u>12605 Connecticut Ave.</u>	
3. NAME OF DECEASED: (Type or Print) <u>Gaetano Lunetta</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan. 15 1956</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Dec 13, 1888</u>
9. AGE last birthday: <u>67</u> yrs.		10. IF UNDER 1 YEAR: Months Days	11. IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bricklayer</u>		10B. KIND OF BUSINESS, OR INDUSTRY: <u>Kay Construction</u>	
11. BIRTHPLACE (State or foreign country): <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>CARL LUNETTA</u>		14. MOTHER'S MAIDEN NAME: <u>LOUISE CANNERATA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>189-03-1844</u>	
17. INFORMANT & ADDRESS: <u>MISS GRACE LUNETTA</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>embolism, shock</u>		<u>15 hrs</u>	
ANTECEDENT CAUSE (B) <u>carcinoma of duodenum</u>		<u>6 mo</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>severe bleeding for 3 wks</u>		<u>3 wks</u>	
19A. DATE OF OPERATION: <u>1-14-56</u>	19B. MAJOR FINDINGS OF OPERATION: <u>Carcinoma of duodenum</u>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory of INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>JAN 13, 1956</u> , to <u>1-15</u> , 1956 that I last saw the deceased alive on <u>JAN 15</u> , 1956, and that death occurred at <u>7:20 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>John C. Roehen</u>		DATE SIGNED <u>1-15-56</u>	
ADDRESS <u>Silver Spring</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>	DATE THEREOF <u>1/18/56</u>	NAME OF CEMETERY OR CREMATORY <u>Wasklawn</u>	LOCATION (City, town, or county) (State) <u>Montgomery Co Md</u>
DATE REC'D BY LOCAL REGISTRAR <u>1-16-56</u>	REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	24. FUNERAL DIRECTOR <u>Warner & Humphrey</u>	ADDRESS <u>8134 8th Ave S.W.</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S. A. GYER

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Montgomery MARYLAND				STATE Virginia COUNTY			
CITY (If outside corporate limits, write RURAL OR and give nearest town) Bethesda Rural				CITY (If outside corporate limits, write RURAL and give nearest town) OR Falls Church			
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital				STREET ADDRESS (If rural give location) 6904 Pine Tree Terrace			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE (Month) (Day) (Year)			
(Type or Print)		Janice Celeste MANSON		OF DEATH JANUARY 7 1956			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months Days Hours Min.		
Female	Cauc.	Single	1-3-56	3 yrs.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None				10B. KIND OF BUSINESS OR INDUSTRY: None		11. BIRTHPLACE (State or foreign country): Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME: Frank Albert MANSON				14. MOTHER'S MAIDEN NAME: Orie Lee PICKREN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No				16. SOCIAL SECURITY NO. -			
17. INFORMANT & ADDRESS: Father: Frank Albert MANSON, 6904 Pine Tree Terrace, Falls Church, Virginia							
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) PNEUMONIA - diffuse							
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Large inter atrial Septal defect							
19A. DATE OF OPERATION: 2				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?							
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from 3 Jan. , 1956 , to 7 Jan. , 1956 , that I last saw the deceased alive on 7 Jan. , 1956 , and that death occurred at 12:35 PM , from the causes and on the date stated above.							
SIGNATURE H.A. PEARSON, LTJG, MC, USN U.S. Naval Hospital, NNMC, Bethesda, Md.				DATE SIGNED 1-8-56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				DATE THEREOF 1-10-56			
NAME OF CEMETERY OR CREMATORY Arlington National Cemetery, Arlington, Virginia				LOCATION (City, town, or county) (State)			
DATE REC'D BY LOCAL REGISTRAR 1-8-56				REGISTRAR'S SIGNATURE Mary E. Carrelly			
24. FUNERAL DIRECTOR Ives Funeral Home, 2847 Wilson Blvd. Arlington, Va.				ADDRESS			

MARGIN RESERVED FOR BINDING

VS. A15-10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 11

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

 00793
 Reg. Dist.

No. 217

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Olney</u>		LENGTH OF STAY (in this place) <u>7 days</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Silver Spring (rural)</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Montgomery County General Hospital, Inc.</u>				STREET ADDRESS (If rural, give location) <u>Rt 2</u>			
3. NAME OF DECEASED: (First) <u>Charles</u>		(Middle) <u>Woodrow</u>		(Last) <u>Marcum</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>January 26 19 56</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>12/18/17</u>	9. AGE last birthday: <u>38</u> yrs.	10. IF UNDER 1 YEAR: Months Days		11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Worked for Contractor</u>		11. BIRTHPLACE (State or foreign country): <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Cecil Marcum</u>				14. MOTHER'S MAIDEN NAME: <u>Corda Sumpter</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u>		(If Yes, give war or dates of service) <u>WW #2</u>		16. SOCIAL SECURITY No.: <u>231-03-1780</u>		17. INFORMANT & ADDRESS: <u>Hospital Record</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Extra. dual hemorrhage</u> DUE TO Antecedent cause(s) (b) <u>lacunar left middle cerebral artery</u> Diseases or conditions, if any, giving rise to the above cause DUE TO <u>fracture of skull</u> stating underlying cause last (c)						<u>9013</u> <u>9 days</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>1/20/56</u>				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) <u>Silver Spring Montg</u>		21d. (State) <u>md</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>1-18-56 2 P.M.</u>		21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fell from ladder</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Broschart</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/> <u>1-27-56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>1/30/56</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l. Cemetery</u>		LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
DATE REC'D BY LOCAL REG. <u>1-28-56</u>		REGISTRAR'S SIGNATURE <u>Gertrude B. Lawler</u>		24. FUNERAL DIRECTOR <u>Wanner & Pumphrey</u>		ADDRESS <u>8434 Ga. Ave. Silver Spring, Md.</u>	

RECEIVED

FEB 1 1956

BUREAU V. S.

828

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00797

CERTIFICATE OF DEATH

Reg. Dist. No. 214

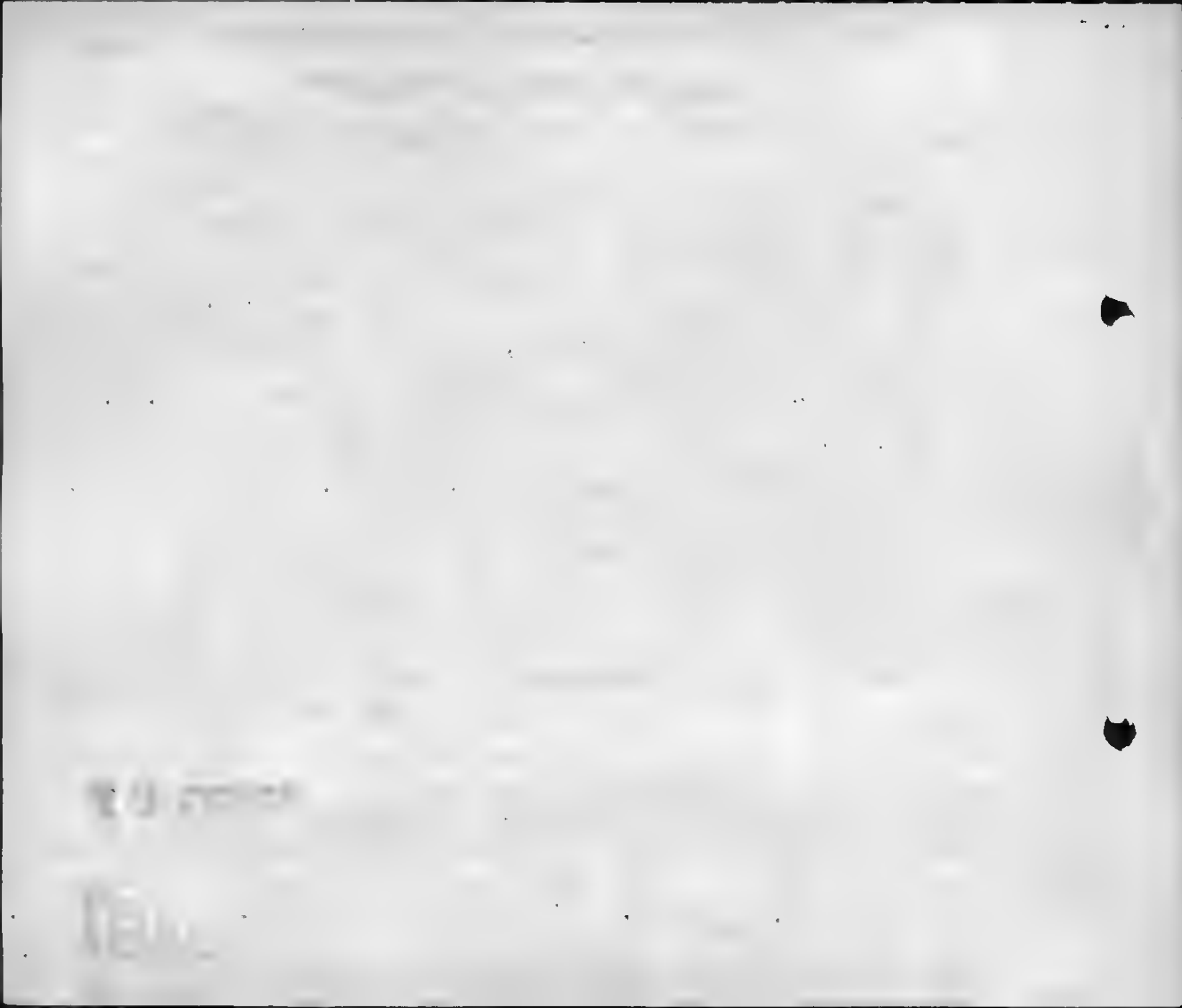
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY MONTGOMERY		STATE MARYLAND		COUNTY MONTGOMERY			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN SILVER SPRING				TOWN FAIRLAND			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 10,800 COLESVILLE ROAD				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
NELLIE ALICE MARLOW				JAN. 29 1956			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
FEMALE	WHITE	WIDOWED	MAY 10, 1869	86 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
HOMEMAKER (retired)		OWN HOME		BELTSVILLE, MARYLAND		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
JOHN H. ROBEY				ALEXENIA ROBEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
NO		NONE		Mr. Fielder T. Marlow, Fairland, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Cardiac decompensation</i>						2-3 yrs	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Arteriosclerosis</i>						?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Hemiplegia (left)</i>						3 days	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1950, to Jan 29, 1956, that I last saw the deceased alive on Jan 29, 1956, and that death occurred at 5:07 P.M. from the causes and on the date stated above.							
SIGNATURE <i>William D. And</i>				ADDRESS (Street, city, town, state)		DATE SIGNED	
						11-30-56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
BURIAL		FEB. 1, 1956		ST. MARK'S CEMETERY		FAIRLAND, MONTGOMERY CO., MD.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
2/2/56		<i>Frances Potter</i>		<i>Warner E. Humphrey</i>		SILVER SPRING, MD.	

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10A



829

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00798

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN RURAL Clarksburg MD</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN RURAL Clarksburg MD</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) (Middle) (Last) <u>JAMES W MASON</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 27 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug 7 1876</u>
9. AGE last birthday <u>79</u> yrs.		10. If under 1 year Months Days Hours Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James H. Mason</u>		14. MOTHER'S MAIDEN NAME <u>Marion Bruce</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-24279</u>	
17. INFORMANT <u>Rev. Sherman Mason</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

415X Immediate cause (a) Heart Failure

Antecedent cause(s) (b) Hyper tension, Cerebrovascular disease

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Anterior mening

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Nov 1955, to 1/27, 1956, that I last saw the deceasedalive on Jan 22, 1956, and that death occurred at 6:00 A.M., from the causes and on the date stated above.SIGNATURE Lucian S. Leal M.D. ADDRESS 1205/56 DATE SIGNED 1/28/56

23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>Jan 30 1956</u>	NAME OF CEMETERY OR CREMATORY <u>St. John's</u>	LOCATION (City, town, or county) <u>Montgomery Co MD</u>	(State)
DATE REC'D BY LOCAL REG. <u>Jan 28, 1956</u>	REGISTRAR'S SIGNATURE <u>Alfred L. Cooke</u>	24. FUNERAL DIRECTOR <u>Roy W. Brehm</u>	ADDRESS <u>Montgomery Co MD</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

THE UNIVERSITY OF CHICAGO

724

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>—</u>		COUNTY <u>—</u>	
CITY (If outside corporate limits, write and give nearest town) <u>Takoma Park</u>		LENGTH OF STAY (in this place) <u>5 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>District of Columbia</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Sanitarium + Hospital</u>				STREET ADDRESS (If rural give location) <u>7600 16th St. N.W.</u>			
3. NAME OF DECEASED: (First) <u>Martha</u> (Middle) <u>May</u> (Last) <u>McCann</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>1</u> <u>1</u> <u>1956</u>			
5. SEX: <u>Fe.</u>		6. COLOR OR RACE: <u>Cauc.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>1-6-81</u>	
				9. AGE last birthday <u>74</u> yrs		IF UNDER 1 YEAR: Months <u>—</u> Days <u>—</u> IF UNDER 24 HRS: Hours <u>—</u> Min. <u>—</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Hswf</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>—</u>		11. BIRTHPLACE (State or foreign country): <u>Massachusetts</u>	
13. FATHER'S NAME: <u>Joseph J. Farwell</u>				14. MOTHER'S MAIDEN NAME: <u>Adriane Healy</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY No. <u>Unk.</u>		17. INFORMANT & ADDRESS: <u>Hospital Records Washington Sanitarium + Hospital</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Hypostatic Pneumonia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
ANTECEDENT CAUSE (B) <u>Obstruction of Ascending Colon</u>				?			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Sirrhous Carcinoma of " "</u>				?			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: <u>due to " " " Abd. wall ?</u>							
19A. DATE OF OPERATION: <u>?</u>				19B. MAJOR FINDINGS OF OPERATION: <u>due to " " " Rt. breast 8 yrs ago</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				21B. PLACE (Home, farm, factory, etc.) OF INJURY: <u>"</u>		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>" Rt. breast 8 yrs ago</u>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>M.</u>				21E. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21F. HOW DID INJURY OCCUR? <u>"</u>	
22. I hereby certify that I attended the deceased from <u>Dec. 26, 1955</u> , to <u>Jan. 1, 1956</u> , that I last saw the deceased alive on <u>Dec. 30, 1955</u> , and that death occurred at <u>3:30 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Paul V. Starr</u>				ADDRESS <u>M. D. Takoma Park, Md.</u>		DATE SIGNED <u>Jan. 1, 1956</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>burial</u>		DATE THEREOF: <u>Jan 3 - 1956</u>		NAME OF CEMETERY OR CREMATORY: <u>Oak Grove Cem.</u>		LOCATION (City, town, or county) (State): <u>Fall River, Mass.</u>	
DATE REC'D BY LOCAL REGISTRAR: <u>Jan. 12 1956</u>		REGISTRAR'S SIGNATURE: <u>J. Wilson Wood</u>		24. FUNERAL DIRECTOR: <u>A. B. Riney Co.</u>		ADDRESS: <u>Washington D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

THEORY

1998

CERTIFICATE OF DEATH

Reg. Dist. No. 214

830

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>md.</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	LENGTH OF STAY (in this place) <u>Some years</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	OR TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>523 Dartmouth Ave.</u>		STREET ADDRESS (If rural give location) <u>523 Dartmouth Ave.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Angelina</u> <u>Meeks</u>		DATE OF DEATH: <u>Jan 27 1956</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>col.</u>	7. SINGLE MARRIED. WIDOWED, DIVORCED. (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>Unk.</u>
9. AGE last birthday: <u>54</u> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): <u>House work.</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Unk.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>EILY MEES</u>		14. MOTHER'S MAIDEN NAME: <u>ELIZA BLAIR</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) <u>No</u> If Yes, give war or dates of service		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Dr. Wilshire - Li 6-8080</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE	(A) <u>Hypertensive + Arteriosclerotic</u>	At least <u>5 yrs</u>	
ANTECEDENT CAUSE (S)	(B) <u>Heart Disease</u>		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Secondary Anemia.</u>			
19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>19</u> , to <u>19</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>927</u> M. from the causes and on the date stated above.			
SIGNATURE <u>Ralph Stiller</u>		ADDRESS <u>927 Kerling Drive - 1127/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>	DATE THEREOF <u>1-30-56</u>	NAME OF CEMETERY OR CREMATORY <u>--</u>	LOCATION (City, town, or county) (State) <u>Jetersville, Va.</u>
DATE REC'D BY LOCAL REGISTRAR <u>1-31-56</u>	REGISTRAR'S SIGNATURE <u>Frances Stiller</u>	24. FUNERAL DIRECTOR <u>W.E. Jamis Co - 1432 4th St. N.W.</u>	ADDRESS <u>178</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

00801

Reg. Dist. No. 216

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bethesda</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5405 Beech Ave.</u>		STREET ADDRESS (If rural, give location) <u>5405 Beech Ave.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>MARIE</u>	(Middle) <u>S</u>	(Last) <u>MEEM</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>CAUCASIAN</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>3-4-1874</u>
9. AGE last birthday <u>81</u> yrs.		10. DATE OF DEATH <u>Jan. 3</u> 19 <u>56</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>C. Edward Meems</u>		14. MOTHER'S MAIDEN NAME <u>Mary J. Moe</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Harry C. Meems, Jr.</u> <u>Nephew-Dickerson, Md.</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>CHRONIC HEART FAILURE</u>			
Antecedent cause(s) (b) <u>BACTERIAL ENDOCARDITIS</u>			
(c) <u>stating the underlying cause last</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>MARCH, 1954</u> , to <u>Jan. 3, 1956</u> , that I last saw the deceased alive on <u>Jan. 3, 1956</u> , and that death occurred at <u>3:00 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Robert J. Thibodeau M.D.</u>		DATE SIGNED <u>Jan 3, 1956</u>	
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>1-6-56</u>	
NAME OF CEMETERY OR CREMATORY <u>St. Roses</u>		LOCATION (City, town, or county) (State) <u>Cloppers Md</u>	
DATE REC'D BY LOCAL REG. <u>1/4/56</u>	REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	24. FUNERAL DIRECTOR <u>Robert C. Thompson</u> ADDRESS <u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

U.S. AIR FORCE

JAN 6

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725
CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH:

COUNTY MONTGOMERY MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town) RURAL
 OR TOWN TAROMA PARK, MD. 11 mos.
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 700 Hudson Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE M.D. COUNTY Montgomery
 CITY (If outside corporate limits, write RURAL and give nearest town) Cherry Chase.
 OR TOWN Cherry Chase.
 STREET ADDRESS (If rural, give location) 6815 Georgia Ave.

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

CLARISSAMELGAARD

4. DATE OF DEATH:

(Month)

(Day)

(Year)

JAN. 11956

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

FWWIDOWEDAUG. 28, 188075 yrs.

Months Days

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

Housewife-MINNESOTAU.S.

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

Peter NelsonHarriet Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

NoNoNone.Mrs. Agnes Arnold6815 Georgia Ave. Cherry Chase, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

INTERVAL BETWEEN ONSET AND DEATH

450.0

Immediate cause

(a).....
DUE TOChronic Heart Failure1 year

Antecedent cause(s)

(b).....
DUE TOAtherosclerosis, General5 years

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 28, 1955, to Jan. 1, 1956, that I last saw the deceased alive on Jan. 1, 1956, and that death occurred at 6:15 P.M., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE) ADDRESS

DATE SIGNED

James A. Roberts M.D.8907 Georgia Ave. Silver Spring, Md.Jan. 1, 1956.

23. BURIAL, CREMATION REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Jan. 1-1956J. Wilson DodgeW. H. Jones Co., Washington D.C.W. H. Jones Co., Washington D.C.

MARGIN RESERVED FOR BINDING

BUREAU V. E.

4 114

RECEIVED
JAN 11 1900

726
CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Montgomery</u> MARYLAND			STATE <u>DC</u> COUNTY		
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Takoma Park</u>			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Washington 16 D.C.</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington San + Hospital</u>			STREET ADDRESS (If rural give location) <u>4814 Sedgwick St. N.W.</u>		
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Mabel Louise Mercer</u>			4. DATE OF DEATH: (Month) (Day) (Year) <u>1 5 1956</u>		
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>wh. ra.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>widow</u>	8. DATE OF BIRTH: <u>2-8-76</u>		
9. AGE last birthday <u>79</u> yrs.			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>housewife</u>		
11. BIRTHPLACE (State or foreign country): <u>D.C.</u>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME: <u>Francis Vaughn</u>			14. MOTHER'S MAIDEN NAME: <u>Louisa Flint</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>none</u>			16. SOCIAL SECURITY No.		
17. INFORMANT & ADDRESS: <u>Daughter - Wash. San + Hosp. records</u>					

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
4 3X IMMEDIATE CAUSE (A) <u>Hypertensive Cardiovascular Dis. w/ Decomposition</u> 15 yrs.		
ANTECEDENT CAUSE (B) DUE TO (C)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 29, 1955 to Jan 5, 1956 that I last saw the deceased alive on Jan 5, 1956, and that death occurred at 11:30 AM, from the causes and on the date stated above.

SIGNATURE J. M. O'Hara ADDRESS M. D. Takoma Park, 12, and. 1-5-56 DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial - 1-7-56 Rock Creek Cemetery</u>	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State) <u>Washington D.C.</u>
DATE REC'D BY LOCAL REGISTRAR <u>Jan 5 1956</u>	REGISTRAR'S SIGNATURE <u>J. M. O'Hara</u>	24. FUNERAL DIRECTOR <u>W. H. Jones Co</u>	ADDRESS <u>2941 14th NW</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUNNELL V. S.

JAN 1

U. S. AIR FORCE

OFFICE



833

CERTIFICATE OF DEATH

Reg. Dist. No. ~~267~~

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Olney</u>	LENGTH OF STAY (in this place) <u>11 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Laurel</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Montgomery County General Hospital, Inc.</u>		STREET ADDRESS (If rural give location) <u>R#2</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year) OF DEATH:	
(First) <u>Emily</u>	(Middle) <u>Louise</u>	(Last) <u>Miles</u>	
(Type or Print)		<u>January 28 1956</u>	
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH: <u>6/9/68</u>
9. AGE last birthday <u>87</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Same</u>	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME: <u>Frederick Renn</u>	
14. MOTHER'S MAIDEN NAME: <u>Katherine</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. _____		17. INFORMANT & ADDRESS: <u>Hospital Records</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Congestive heart failure</u>			<u>3 wks.</u>
ANTECEDENT CAUSE (B) <u>Chronic myocarditis</u>			<u>5 yrs</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>C</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>June</u> ..., 19 <u>54</u> , to <u>Jan</u> ..., 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 27</u> ..., 19 <u>56</u> , and that death occurred at <u>1:50 a. M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Dr. Bonigant</u>		DATE SIGNED <u>1/28/56</u>	
ADDRESS <u>Sandy Spring Md</u>		M.D. <u>1/28/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>January 30 1956</u>	
NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Jan 30 - 56</u>		REGISTRAR'S SIGNATURE <u>Esther B Fowler</u>	
24. FUNERAL DIRECTOR <u>Dr. Witt, Donaldson, Laurel, Md</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

834

CERTIFICATE OF DEATH

00805

Reg. Dist. No. 214

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY MONTGOMERY		STATE MARYLAND		COUNTY MONTGOMERY			
CITY (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 628 SLIGO AVENUE				STREET ADDRESS (If rural give location) 628 SLIGO AVENUE			
3. NAME OF DECEASED (First) MARGARET (Middle) ELLEN (Last) MILLER				4. DATE OF DEATH (Month) JAN. (Day) 25 (Year) 19 56			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH MARCH 5, 1891		9. AGE (last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) WASHINGTON, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES PRESTON BARNES				14. MOTHER'S MAIDEN NAME ANNIE ROBEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE		17. INFORMANT & ADDRESS MRS. LeROY AYERS, 628 SLIGO AVE. SILVER SPRING, MARYLAND			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) Pulmonary Embolism						INTERVAL BETWEEN ONSET AND DEATH 12 hrs.	
ANTECEDENT CAUSE(S) DUE TO (B) Pulmonary Thrombosis						None	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan. 15, 1956, to Jan. 25, 1956, that I last saw the deceased alive on Jan. 24, 1956, and that death occurred at 8:35 A.M. from the causes and on the date stated above.							
SIGNATURE <i>John R. Rogers</i>				DATE SIGNED 1919 January 27, 1956			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 1/28/56		NAME OF CEMETERY OR CREMATORY COLESVILLE CEMETERY		LOCATION (City, town, or county) MONTGOMERY COUNTY, MD.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Frances Potter</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Warner E. Humphrey</i>			
DATE 1-23-56		ADDRESS SILVER SPRING, MD.					



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00806

Reg. Dist. No.

2/5

CERTIFICATE OF DEATH

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL OR TOWN) <u>Bethesda</u>		LENGTH OF STAY (In this place) <u>24 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Frederick</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center Bethesda, Maryland</u>				STREET ADDRESS (If rural give location) <u>731 North Market Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Virginia H. Miller</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan. 6, 1956</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>January 13, 1903</u>	9. AGE last birthday <u>52</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housekeeper</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Domestic</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>J. Marshall Miller</u>				14. MOTHER'S MAIDEN NAME: <u>Fannie Harling</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unk.) <u>No</u>		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service) <u>None</u>		17. INFORMANT & ADDRESS: <u>The Medical Record, The Clinical Center</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Hepatic Coma and Hypertension</u>						<u>1 week</u>	
ANTECEDENT CAUSE (B) <u>Carcinoma of Breast with metastases</u>						<u>1 1/2 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>Dec. 18, 1955</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Adrenal metastases, oophorectomy, appendectomy and biliary adenectomy</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21B. PLACE (Home, farm, factory, street, office bldg., etc.) <u>none</u>		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec. <u>13, 1955</u> to Jan. <u>6, 1956</u> that I last saw the deceased alive on <u>Jan. 6, 1956</u> , and that death occurred at <u>9:45 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Richard A. Paton</u>		ADDRESS <u>The Clinical Center, NIH, Bethesda, Md.</u>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/9/56</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		LOCATION (City, town, or county) (State) <u>Frederick Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>8 Jan. 1956</u>		REGISTRAR'S SIGNATURE <u>Mary G. Fanelly</u>		24. FUNERAL DIRECTOR <u>H. E. Early Co. Frederick Md</u>		ADDRESS	

ROMANOV Y. S.

1917

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISE 1-55 10A

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

836

CERTIFICATE OF DEATH

00807

Reg. Dist. No. 218

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Montgomery</u>		STATE <u>Maryland</u>		COUNTY <u>Prince George</u>		NAME <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
X TOWN <u>Seaside</u>		<u>3 months</u>		TOWN <u>Indian Head</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Maryland Rest Home</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Catherine</u> (Middle) <u>H.</u> (Last) <u>Milstead</u>				(Month) <u>Jan</u> (Day) <u>29</u> (Year) <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>July 26, 1875</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Bowie</u>				14. MOTHER'S MAIDEN NAME <u>Ella Hoffmann</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT & ADDRESS <u>Earl Milstead Indian Head, Md</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
19a. IMMEDIATE CAUSE (A) <u>Hypostatic pneumonia</u>						<u>2 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinomatosis</u>						<u>2 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Diabetes mellitus</u>						<u>3 months</u>	
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION <u>none</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>23 Nov</u> , 19 <u>55</u> , to <u>29 Jan</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>28 Jan</u> , 19 <u>56</u> , and that death occurred at <u>9:15 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>John S. Lawrence</u> M.D.				ADDRESS (Street, city, town, state) <u>P.O. Box Maryland 29 Jan. 56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>23 Jan 56</u>		DATE THEREOF <u>1/29/56</u>		NAME OF CEMETERY OR CREMATORY <u>Neptune Cemetery</u>		LOCATION (City, town, or county) (State) <u>Persimmon Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Jan. 3/56</u>		<u>Charles L. Cook</u>		<u>Orchard Funeral Home Inc</u>		<u>Suplaton md.</u>	



837

CERTIFICATE OF DEATH

Reg. Dist. No. 216...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>DC</u>		COUNTY <u>47</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>24 Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		<u>D.C.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Resmon Hospital 5721 Grosvenor LA. Beth.</u>				STREET ADDRESS (If rural give location) <u>2131 O St. N.W.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>MARY JANE MOORE</u>				<u>JANUARY 13 1956</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>SINGLE</u>	8. DATE OF BIRTH: <u>2/14/1911</u>	9. AGE last birthday <u>84</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Gov't work</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>U.S. Gov't.</u>		11. BIRTHPLACE (State or foreign country): <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Edwin Moore</u>				14. MOTHER'S MAIDEN NAME: <u>Mildred Lynn</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS: <u>Mrs. Teresa O'Brien-2131 O St. N.W. D.C.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Myocardial infarct</u>						<u>5 weeks.</u>	
ANTECEDENT CAUSE (B) <u>senility, general debility</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>a recent fracture left hip & carcinoma of breast</u>						<u>11 yrs.</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 6, 1955</u> to <u>Jan 13, 1956</u> (that I last saw the deceased alive on <u>Jan 12, 1956</u> , and that death occurred at <u>10 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>John J. Dolan</u>		M. D. <u>3100 Conn Ave</u>		DATE SIGNED <u>1/13/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/16</u>		NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>		LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-16-56</u>		REGISTRAR'S SIGNATURE <u>Bennie M. Thompson</u>		24. FUNERAL DIRECTOR <u>2900 14th St N.W. WASHINGTON D.C.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Reported to & approved by the
Montgomery County Medical Examiner.
John V. Dolan M.D.

RECEIVED
JAN 11 1900
F. S.

838

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00809

CERTIFICATE OF DEATH

Reg. Dist. No. 215.....

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Montgomery	MARYLAND	STATE Maryland	COUNTY Montgomery
CITY (If outside corporate limits, write RURAL OR and give nearest town) Bethesda Rural	LENGTH OF STAY (in this place) 9hrs 10 min	CITY (If outside corporate limits, write RURAL and give nearest town) Bethesda	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital		STREET ADDRESS (If rural give location) 7005 Exeter Road	
3. NAME OF DECEASED: (First) (Middle) (Last) Gail Whitney MUFFITT		4. DATE (Month) (Day) (Year) OF DEATH: January 5 1956	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: 7-21-55
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None		10B. KIND OF BUSINESS OR INDUSTRY: None	9. AGE last birthday: 5 yrs. 13 Months 13 Days 19 Hours 56 Min.
11A. FATHER'S NAME: Dempster MUFFITT		11B. MOTHER'S MAIDEN NAME: Jean GELENIUS	
12. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) - -		13. SOCIAL SECURITY NO. - -	
14. INFORMANT & ADDRESS: Father Dempster MUFFITT HMC USN Same as above			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) Interstitial pneumonia		10 hours
ANTECEDENT CAUSE (B) DUE TO		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: Meningismus w/ Cardiac dilatation	
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19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4 Jan , 19 56 , to 5 Jan , 19 56 , that I last saw the deceased alive on 5 Jan , 19 56 , and that death occurred at 5:55A , M, from the causes and on the date stated above.	
SIGNATURE R. L. S. BAIRD	DATE SIGNED
R. L. S. BAIRD LTJG, MC, USNR U. S. Naval Hospital, NMMC, Bethesda, Maryland	

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	9 Jan 1956	Private Cemetery	Hillsdale, Michigan

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
5 Jan 1956	Mary E. Garsella	R. A. Pumphrey Funeral Home	7557 Wisconsin Avenue, Bethesda, Md.

MARGIN RESERVED FOR BINDING

VS. A15-10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 11 1900

RECEIVED

839

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY Montgomery	MARYLAND		STATE Maryland	COUNT Frederick	
CITY (If outside corporate limits, write RURAL and give nearest town) Olney			CITY (If outside corporate limits, write RURAL and give nearest town) Rural - Kempton		
HOSPITAL OR INSTITUTION OR STREET ADDRESS Montgomery County Gen. Hospital			STREET ADDRESS (If rural give location) R.F.D. Mt. Airy		
3. NAME OF DECEASED: (Type or Print)			4. DATE OF DEATH:		
(First) Annie (Middle) - (Last) Mullinix			(Month) Jan. (Day) 17 (Year) 19 56		
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:		9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.
Female	White	Married	March 1, 1889		66 yrs. Months Days Hours Min.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired Housewife			10b. KIND OF BUSINESS OR INDUSTRY: Own Home		11. BIRTHPLACE (State or foreign country): Frederick County, Md.
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME: Basil F. Buxton		
14. MOTHER'S MAIDEN NAME: Louisa H. Moxley			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		
16. SOCIAL SECURITY No.: None			17. INFORMANT & ADDRESS: Mrs Ellsworth Mullinix, Mt. Airy, Md.		

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				Interval Between Onset And Death	
4-3x Immediate cause (a) Hypertensive Heart Disease DUE TO with terminal irreversible congestive heart failure. Antecedent causes (s) (b) heart failure. Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (c)				5 years	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Bronchial Asthma					
19a. DATE OF OPERATION: none		19b. MAJOR FINDINGS OF OPERATION: none		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify) No		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan. 17, 1935, to January 17, 1956, that I last saw the deceased alive on Jan 17, 1956, and that death occurred at 10:00 PM, from the causes and on the date stated above.					
SIGNATURE M. McKendree Boyer		DATE THEREOF Jan. 20, 1956		ADDRESS Providence Cemetery, Kempton, Md.	
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		NAME OF CEMETERY OR CREMATORY Providence Cemetery		LOCATION (City and State) Kempton, Md.	
DATE REC'D BY LOCAL REGISTRAR 1-23-56		REGISTRAR'S SIGNATURE Gertrude B. Lawler		24. FUNERAL DIRECTOR Olin L. Molesworth	
				ADDRESS Damascus 1/19/56	

BUREAU A. L.

JAN 27

RECEIVED
JAN 27 1954

849

CERTIFICATE OF DEATH

Reg. Dist. No. 213

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Rockville</u>		LENGTH OF STAY (in this place) <u>20 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Rockville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED: (First) <u>JOHN</u> (Middle) <u>P</u> (Last) <u>MYERS</u>			4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan.</u> <u>14</u> <u>19 56</u>				
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Nov. 21 1891</u>		9. AGE last birthday <u>64</u> yrs.		IF UNDER 1 YEAR: Months <u>2</u> Days <u>23</u> Hours <u></u> Min. <u></u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Adminis. Asst. Coast Gdard Gov.</u>			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME: <u>John P. Myers Sr.</u>				14. MOTHER'S MAIDEN NAME: <u>Isabel Luther</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>WW I</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Wife-Babette C. Myers, RFD #4, Rockville</u>		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Respiratory failure</u>						<u>15 min.</u>	
ANTECEDENT CAUSE (B) <u>Metastatic Carcinoma</u>						<u>6 mos.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Refractory - carcinoma of mammary</u>						<u>10 months</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION: <u>Refractory - carcinoma & metastases</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9/1/52</u> to <u>1/14/56</u> that I last saw the deceased alive on <u>1/14/56</u> , and that death occurred at <u>8:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Stephen R. Jones M.D.</u>		ADDRESS <u>Rockville Md</u>		DATE SIGNED <u>1/16/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		DATE THEREOF <u>1-17-56</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		LOCATION (City, town, or county) (State) <u>Prince Georges Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2/1/56</u>		REGISTRAR'S SIGNATURE <u>Laurel H. Bentley</u>		24. FUNERAL DIRECTOR <u>Robt. R. Lumsden</u>		ADDRESS <u>Bethesda, Md.</u>	

J. A. O'NEILL

FEB

841

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
X TOWN <u>Bethesda</u>		<u>67</u> days		TOWN <u>Bethesda</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center Bethesda, Maryland</u>				STREET ADDRESS (If rural give location) <u>5524 Oakmont Avenue</u>			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(Type or Print)		(First)	(Middle)	(Last)	OF DEATH:	Jan.	8,
		<u>Mary</u>	<u>Hiley</u>	<u>Nasuti</u>			<u>19 56</u>
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:		9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>February 5, 1899</u>		<u>56</u> yrs.	Months	Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>None</u>			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?
					<u>Alabama</u>		<u>U. S. A.</u>
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Eugene Hiley</u>				<u>Mary E. Matthews</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>No</u>				<u>Not available</u>		<u>The Medical Record, The Clinical Center</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Adhesive Pericarditis</u>							<u>weeks</u>
ANTECEDENT CAUSE (B) <u>Metastatic Carcinoma, lungs and mediastinum</u>							<u>5 months</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Carcinoma, left breast</u>							<u>3 years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<u>2</u>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While at work Not while at work		21F. HOW DID INJURY OCCUR?	
<u>none</u> M.							
22. I hereby certify that I attended the deceased from Nov. 2, 1955, to Jan. 8, 1956, that I last saw the deceased alive on Jan. 8, 1956, and that death occurred at 6:04 PM, from the causes and on the date stated above.							
SIGNATURE <u>Robert G. Lusk</u>				ADDRESS <u>The Clinical Center</u> DATE SIGNED <u>1/9/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>				<u>1-12-56</u>		<u>Arlington National</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/12/56</u>				REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		FUNERAL DIRECTOR ADDRESS <u>Robert A. Humphrey Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

20 1/2 (19-0000)

1

842

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>MONTGOMERY.</u> MARYLAND				STATE <u>MARYLAND</u> COUNTY <u>MONTGOMERY.</u>			
CITY (If outside corporate limits, write RURAL or and give nearest town) <u>BETHESDA 14, MD.</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BETHESDA 14, MD.</u>			
TOWN <u>BETHESDA 14, MD.</u> LENGTH OF STAY (in this place) <u>10 YRS.</u>				STREET ADDRESS (If rural give location) <u>4217 ADELAIDE DRIVE.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>NONE.</u>							
3. NAME OF DECEASED: (First) (Middle) (Last) <u>PAUL HOWARD NETTLETON.</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>JANUARY 1, 1956.</u>			
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Specify): <u>MARRIED.</u>	8. DATE OF BIRTH: <u>AUGUST 27, 1908</u>	9. AGE last birthday <u>47</u> yrs.	IF UNDER 1 YEAR Months <u>4</u> Days <u>4</u>	IF UNDER 24 HRS. Hours <u>4</u> Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>GOVERNMENT ANALYST</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>U.S. GOVERNMENT</u>		11. BIRTHPLACE (State or foreign country): <u>MINNESOTA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>							
13. FATHER'S NAME: <u>GEORGE HOWARD NETTLETON.</u>				14. MOTHER'S MAIDEN NAME: <u>ELEANOR SHEEHAN.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO.</u>				16. SOCIAL SECURITY NO. <u>? NO</u>		17. INFORMANT & ADDRESS: <u>JOAN KATHRYN RAMSAY, 316 MT. VERNON PL. ROCKVILLE, MD</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						DAUGHTER.	
IMMEDIATE CAUSE (A) <u>ACUTE CORONARY OCCLUSION.</u>						5 MINUTES	
ANTECEDENT CAUSE (B) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>						6 MOS.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>NONE.</u>							
19A. DATE OF OPERATION: <u>NONE.</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> M.		21F. HOW OLD INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>January 1, 1956</u> , to <u>January 1, 1956</u> , that I last saw the deceased alive on <u>January 1, 1956</u> , and that death occurred at <u>11:55 P. M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Bessie M. Thompson</u>				DATE SIGNED <u>1/2/56.</u>			
ADDRESS <u>M. O. 9300 EWINO DR. BETHESDA 14, MD.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/4/1956</u>		NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		LOCATION (City, town, or county) (State) <u>Rockville Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Jan 3-56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR ADDRESS <u>Robert A. Humphrey Bethesda, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Spoke with Deputy Coroner Dr. John
Ball per telephone approximately 15 minutes after
demise of patient. He gave permission for
release of body to undertaker.

1/2/56.

Seymour Granbaum, M.D.

BUREAU V. S.

JAN 5 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

COUNTY Montgomery MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR TOWN Takoma Park LENGTH OF STAY (in this place) 6 days
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington San. & Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE District of Columbia
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR TOWN Washington 4702
 STREET ADDRESS (If rural give location)
1443 Spring Rd., N.W.

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print) Fred (None) Niccum

4. DATE (Month) (Day) (Year) OF DEATH: 1 27 1956

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday

IF UNDER 1 YEAR
 Months Days Hours Min.
 70 yrs.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS:

18. MEDICAL CERTIFICATION
 I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE

(A)

ANTECEDENT CAUSE (S)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While ☐ Not while ☐ at work ☐ at work

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1953, 19, to 1/27/1956, that I last saw the deceased

alive on 1/27/1956 and that death occurred at 5⁴⁵ P. M., from the causes and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

TRANSIT BURIAL
1-30-56

CONVERSE
INDIANA.

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

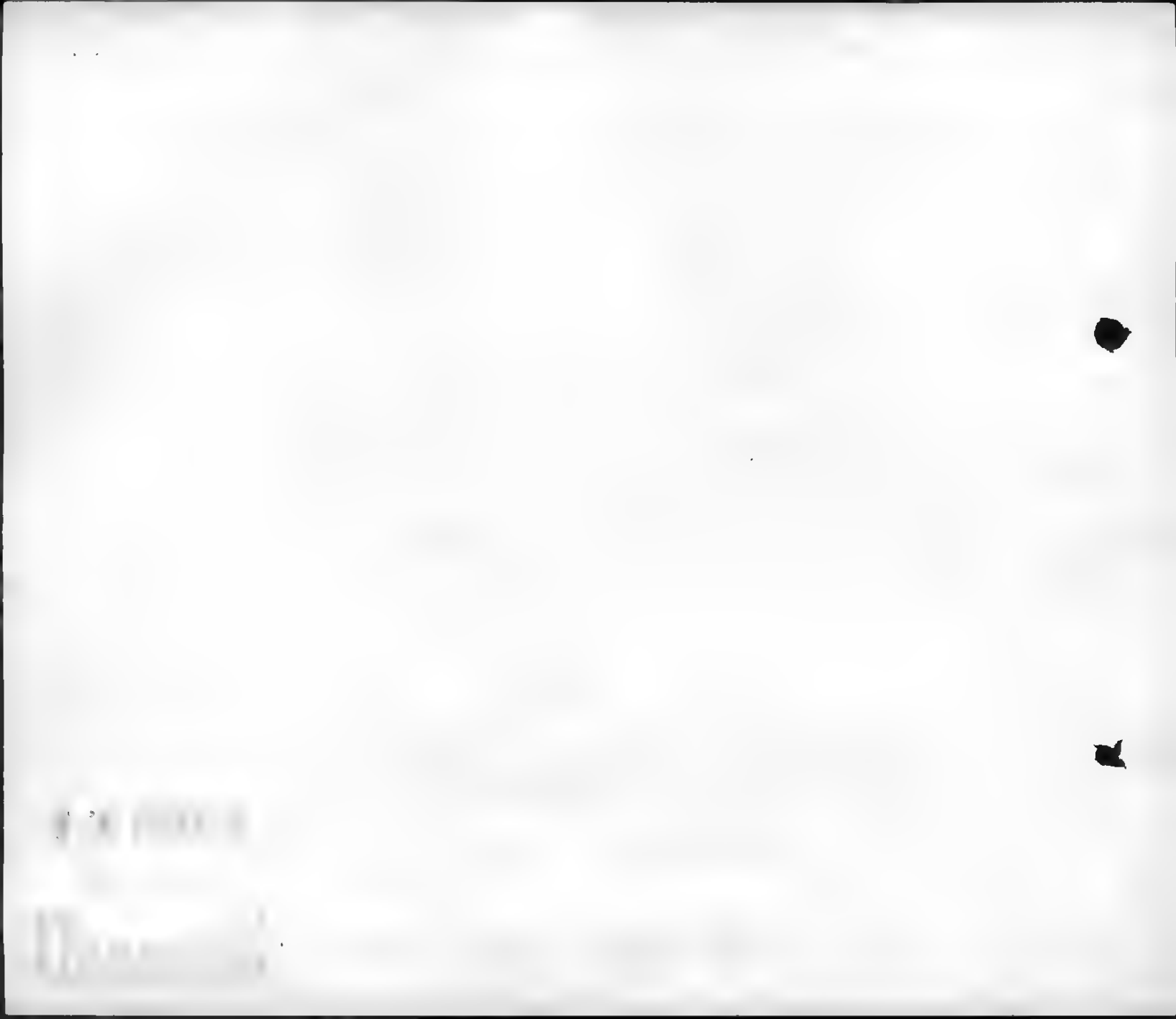
Jan. 27-1956
J. M. M. D. D.

J. M. M. D. D.

The S. H. M. Co. 2901 14th St. N.W. Wash. D.C.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00814

843

CERTIFICATE OF DEATH

Reg. Dist. No. 2.17

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		LENGTH OF STAY (in this place) <u>1 yr.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg,</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mont. General Hospital, Inc.</u>				STREET ADDRESS (If rural give location) <u>Route #1</u>			
3. NAME OF DECEASED: (First) <u>Bradley</u> (Middle) <u>Johnson</u> (Last) <u>Nichols, Jr.</u>				4. DATE (Month) <u>1</u> (Day) <u>20</u> (Year) <u>19 56</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>		8. DATE OF BIRTH: <u>2/8/54</u>	
9. AGE last birthday: <u>1</u> yrs.		IF UNDER 1 YEAR: Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>1</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>None</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>None</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>							
13. FATHER'S NAME: <u>Bradley Johnson Nichols, Sr.</u>				14. MOTHER'S MAIDEN NAME: <u>Virgie Redmond</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS:	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Pneumonia - Ecto -</u>						<u>18 hours</u>	
ANTECEDENT CAUSE (B) <u>undetermined</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>Jan. 17, 1956</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 17, 1956</u> , to <u>Jan. 20 1956</u> , that I last saw the deceased alive on <u>Jan. 20, 1956</u> , and that death occurred at <u>4:30 P. M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Jack Summacker</u>				DATE SIGNED <u>Jan. 20-56</u>			
M. D. <u>Gaithersburg, Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>		DATE THEREOF <u>Jan. 23 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Wheatonville</u>		LOCATION (City, town, or county) (State) <u>Wheatonville Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-24-56</u>		REGISTRAR'S SIGNATURE <u>Certitude B. Lawler</u>		24. FUNERAL DIRECTOR <u>W. Barber</u>		ADDRESS <u>Wheatonville Md</u>	

BUREAU V. S.

JAN 25 19

RECEIVED
JAN 25 19

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00815

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Bethesda</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Bethesda</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4526 Avondale Street</u>				STREET ADDRESS (If rural give location) <u>4526 Avondale Street</u>			
3. NAME OF DECEASED: (First) <u>Sarah</u>		(Middle) <u>NITZ</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>January 18 19 56</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>Mch 16, 1869</u>	9. AGE last birthday <u>86</u> yrs.	IF UNDER 1 YEAR: Months <u>9</u> Days <u>2</u>	IF UNDER 24 HRS: Hours <u></u> Min. <u></u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>- - - - -</u>		11. BIRTHPLACE (State or foreign country): <u>Virginia</u>	
13. FATHER'S NAME: <u>Unknown</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Mrs. Lena Morris--Same Item #2</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Carcinoma - undetermined origin</u>						<u>6 months</u>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH? (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 18, 1956</u> , to <u>Jan 18, 1956</u> , that I last saw the deceased alive on <u>January 18, 1956</u> , and that death occurred at <u>12:10 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Robert E. Sawyer</u>		M.D. <u>Bethesda 14 Md</u>		DATE SIGNED <u>Jan 18, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan 21, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Edgewood</u>		LOCATION (City, town, or county) (State) <u>Mt. Horeb Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/20/56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Robert A. Humphreys</u>		ADDRESS <u>Bethesda, Md.</u>	

W. W. W. W.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

845

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 008166

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Mont.</u>
CITY (If outside corporate limits, write OR and give nearest town) <u>Bethesda</u>	LENGTH OF STAY (in this place) <u>10 min.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hosp</u>		STREET ADDRESS (If rural give location) <u>2406 Churchill Road</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Shirley Morris Oehmann</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan. 3 1956</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Feb. 4, 1920</u>
9. AGE last birthday <u>35</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Washington, D.C.</u>	11. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		13. KIND OF BUSINESS OR INDUSTRY: <u>own home</u>	
14. FATHER'S NAME: <u>Andrew J. Morris</u>		15. MOTHER'S MAIDEN NAME: <u>Frances McEnaney</u>	
16. WAR DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		17. SOCIAL SECURITY NO. <u>578-12-5576</u>	
18. MEDICAL CERTIFICATION		19. INFORMANT & ADDRESS: <u>Andrew F. Oehmann - above</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Diabetic Coma</u>	DUE TO	<u>2 hrs</u>	
ANTECEDENT CAUSE (B) <u>Diabetic Acidosis</u>	DUE TO	<u>10 hrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>Diabetes Mellitus</u>	(C)	<u>12 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY—street, office bldg., etc.)	21C. WHERE DID (City or town) INJURY OCCUR?	(County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Oct 27, 1955</u> , to <u>3 Jan., 1956</u> , that I last saw the deceased alive on <u>27 Dec., 1955</u> , and that death occurred at <u>8:55 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Merlyn J. White</u>	M.D. <u>11134 Georgia Ave</u>	DATE SIGNED <u>Jan 3, 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>1/6/56</u>	NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State) <u>Arlington National Cemetery Arlington, Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/4/56</u>	REGISTRAR'S SIGNATURE <u>Beau M. Thompson</u>	24. FUNERAL DIRECTOR ADDRESS <u>Warner E. Humphrey, 8434 Ga. Ave. Silver Spring, Md.</u>	

S. A. 100000

W. A. 100000

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

846
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00817

Reg. Dist.

No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Montgomery		MARYLAND		STATE Maryland		COUNTY Montgomery	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
X TOWN Glen Echo Heights				TOWN Glen Echo Heights			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		5404 Waneta Road		STREET ADDRESS (If rural, give location)			
				5404 Waneta Road			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE OF DEATH			
(Type or Print) William		C. OLIVEY		January 7 19 56			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
Male		White		Single		Oct. 12, 1955	
9. AGE last birthday:		10. BIRTHPLACE (State or foreign country):		11. CITIZEN OF WHAT COUNTRY?		USA	
0 yrs.							
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
None		None				USA	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Herbert M. Olivey				Betty Jane Nagle			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
No		None		Same as Item #2 Mrs. Betty J. Olivey			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
493X Immediate cause (a) <u>Respiratory Insufficiency</u> DUE TO						20 min.	
Antecedent cause(s) (b) <u>Virus Pneumonia</u> DUE TO						2 days	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
2							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		John B. Ball		M. D.		DATE SIGNED	
						Jan 7, 1956	
23. BURIAL-CREMATATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial-Transit		1-9-56		Woodlawn Cemetery		Chemung County, New York	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
1/9/56		Beattie M. Thompson		Robert A. Humphrey		Bethesda, Md.	

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Iter 14, Filed 1971-1-13-56 et

CERTIFICATE OF DEATH

Reg. Dist. No. 223...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Sakoma Park -</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Sakoma Park -</u>		17	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7814 Garland Ave -</u>				STREET ADDRESS (If rural give location) <u>7814 Garland Ave</u>		1	
3. NAME OF DECEASED: (First) <u>Harriet</u> (Middle) <u>Owen</u> (Last) <u>Owen</u>				4. DATE (Month) (Day) (Year) OF DEATH <u>JAN 5 1956</u>			
5. SEX. <u>F</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH <u>AUG 29, 1864</u>	
9. AGE last birthday: <u>91</u> yrs		10. USUAL OCCUPATION (Give kind of work done during working life) <u>OWNED ROOMING HOUSE (RETIRED)</u>		11. BIRTHPLACE (State or foreign country): <u>ENGLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME: <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT & ADDRESS: <u>JAMES B. PARKHILL, 326 NORTHWEST DRIVE SILVER SPRING, MD.</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Acute Coronary Thrombosis</u>						1-2 hrs.	
ANTECEDENT CAUSE (B) <u>Senile Arteriosclerosis</u>						20 yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C) <u>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</u>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>JAN 5, 1956</u> to <u>5 Jan, 1956</u> , that I last saw the deceased alive on <u>5 Dec</u> , 19 <u>55</u> , and that death occurred at <u>8 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>J. B. Queen</u> ADDRESS <u>7112 W. Willow Ave Takoma Park</u> DATE SIGNED <u>5 JAN 1956</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>CREMATION</u>		DATE THEREOF <u>JAN. 7, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CREMATORY</u>		LOCATION (City, town, or county) (State) <u>P.A. AVE. EXT., PRGED. CO. MD.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>JAN. 5-1956</u>		REGISTRAR'S SIGNATURE <u>J. B. Queen</u>		24. FUNERAL DIRECTOR <u>Adelbert Walters</u>		ADDRESS <u>254 S. Carroll St. D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Miss Owen was found dead in bed
by neighbors this A.M. Since she was 91
and had advanced arteriosclerosis with
coronary insufficiency, I feel she had
an unquestionable coronary heart attack.
Medical examiner Dr. John Bell
notified and permission granted
for me to sign this certificate.

J. H. B. Allen M.D.

MARYLAND

847

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Mont.</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Rural Silver Spring</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cedarcroft Sanitarium</u>		STREET ADDRESS (If rural, give location) <u>Lincoln Park</u>	
3. NAME OF DECEASED (First) <u>Ernest</u> (Middle) <u>A.</u> (Last) <u>Palmer, Jr.</u>		4. DATE OF DEATH (Month) <u>January</u> (Day) <u>7</u> (Year) <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>May 27, 1906</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <u>Ernest Palmer Sr</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
12. CITIZEN OF WHAT COUNTRY?		14. MOTHER'S MAIDEN NAME <u>Ellen Greene</u>	
17. INFORMANT AND ADDRESS <u>Mrs Ellen Palmer Rockville, Md.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <u>(a) asphyxiation from aspiration of vomitus</u>		<u>Antecedent cause(s) <u>aleplism bringing on vomiting, diarrhea from gastroenteritis.</u></u> <u>3. and <u>Patient had alcoholic hallucinosis</u></u>	<u>Several days</u>
Antecedent cause(s)			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 1-6, 1956 to 1-7, 1956 that I last saw the deceased alive on 1-7, 1956 and that death occurred at 12:45 P. from the causes and on the date stated above.

SIGNATURE <u>Ernest J. Kistler M.D. Silver Spring, Md.</u>		DATE SIGNED <u>1/10/56</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Lincoln Park.,</u>	
DATE REC'D BY LOCAL REG. <u>1/10/56</u>		LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>	
REGISTRAR'S SIGNATURE <u>Laurel H. Bryant</u>		24. FUNERAL DIRECTOR <u>Robert L. Sworden Rockville, Md.</u>	

MARGIN RESERVED FOR BINDING



CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Prince Georges</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <u>Takoma Park</u>		<u>1 hr 20 min</u>		OR TOWN <u>Landover</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Sanitarium + Hospital</u>				STREET ADDRESS (If rural give location) <u>3709 Harmond Ave.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Armand Stephen Pattago</u>				OF DEATH: <u>1 - 1</u> 19 <u>56</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH: <u>5-24-1912</u>	
9. AGE last birthday <u>43</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 MRS.			
Months		Days		Hours		Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Security Policeman</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Hopkins University</u>		11. BIRTHPLACE (State or foreign country): <u>Maine</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>				13. FATHER'S NAME: <u>John G. Pattago</u>			
14. MOTHER'S MAIDEN NAME: <u>Aurora D. Champlain</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes W.W. 2</u>			
16. SOCIAL SECURITY NO. <u>Unk.</u>				17. INFORMANT & ADDRESS: <u>Hospital Records Washington Sanitarium + Hospital.</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Acute myocardial infarction</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>			
ANTECEDENT CAUSE (B) <u>Coronary atherosclerosis</u>				<u>Several yrs.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			
21C. WHERE DID (City or town) (County) (State)				21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>December 31, 1955</u> , to <u>January 1, 1956</u> , that I last saw the deceased alive on <u>January 1, 1956</u> , and that death occurred at <u>12³⁰ AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Bennet A. Porter, M.D.</u>				ADDRESS <u>M. D. 9301 Coleridge Rd., Silver Spring, Md.</u>			
DATE SIGNED <u>January 1, 1956</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/4/56</u>		NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L CEM.</u>		LOCATION (City, town, or county) (State) <u>ARLINGTON, VA.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Jan 1 - 1956</u>		REGISTRAR'S SIGNATURE <u>J. Wilson Deeds</u>		24. FUNERAL DIRECTOR <u>W.W. Chambers Co - Riverdale, Md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr Broschart contacted by Dr Porter
Approval given
m. Darrell R. K.

EDWARD V. S.

1915

248 Item 1, Film 92 1-30-56 et

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00821
Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 217

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)	
TOWN <u>Blair</u>	<u>804</u>	TOWN <u>Manor Club, Rockville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Monty ex. Gen Hosp</u>		STREET ADDRESS (If rural, give location) <u>1427 Crossway Road</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
<u>Frank A. Pellegrini</u>		<u>January 14 1956</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>Nov. 7, 1904</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Attorney</u>		10b. KIND OF BUSINESS OR INDUSTRY:	9. AGE last birthday: <u>51</u> yrs.
13. FATHER'S NAME: <u>Constant Pellegrini</u>		14. MOTHER'S MAIDEN NAME: <u>Theresa Primavera</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u> (If Yes, give war or dates of service) <u>WW #2</u>		16. SOCIAL SECURITY NO.: <u>579-48-1690</u>	
		17. INFORMANT & ADDRESS: <u>Mrs. Rena S. Pellegrini, 1427 Crossway Rd.</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		18. MEDICAL CERTIFICATION	
Immediate cause (a) <u>Coronary occlusion</u>		Interval Between Onset and Death <u>sudden death</u>	
Antecedent cause(s) (b) <u>giving rise to the above cause stating underlying cause last</u>			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>Frank J. Brochant</u>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>1-14-56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Trans. & Burial</u>		DATE THEREOF <u>1/19/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		LOCATION (City, town, or county) (State) <u>Seattle, King County, Washington</u>	
DATE REC'D BY LOCAL REG. <u>Jan 15-56</u>		REGISTRAR'S SIGNATURE <u>Gertrude B. Lawler</u>	
		24. FUNERAL DIRECTOR <u>Wanner & Humphrey</u> ADDRESS <u>8434 Ga. Ave. Silver Spring, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 19 1956

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

849

CERTIFICATE OF DEATH

Reg. Dist. No. 0082213

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Prince Georges</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Bethesda</u>	<u>1 wk. 1 day</u>	TOWN <u>Washington 28</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hosp</u>		STREET ADDRESS (If rural give location) <u>7520 Marlboro Pike</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Josephine Peterson</u>		OF DEATH: <u>Jan 8 1956</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOWED</u>	8. DATE OF BIRTH: <u>Dec. 17, 1869</u>
9. AGE last birthday <u>86</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
		Months	Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Brooklyn, New York</u>
13. FATHER'S NAME: <u>Armstrong</u>		14. MOTHER'S MAIDEN NAME: <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		18. SOCIAL SECURITY NO.	
		17. INFORMANT & ADDRESS: <u>Frieda Wood - Sister-in-law</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE <u>332X</u>			
ANTECEDENT CAUSE (S):			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) <u>Massive cerebral infarction</u>			<u>? days</u>
DUE TO			
(B) <u>Arteriosclerosis, Cerebral</u>			<u>? years</u>
DUE TO			
(C) <u>Senility</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Branchopneumonia, left lower lobe</u>			<u>? days</u>
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.)	21C. WHERE DID (City or town) INJURY OCCUR?	(County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>31 Dec, 1955</u> , to <u>8 Jan, 1956</u> , that I last saw the deceased alive on <u>8 Jan, 1956</u> , and that death occurred at <u>1:15 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		ADDRESS <u>M.D. Suburban Hosp. Bethesda Md.</u> DATE SIGNED <u>9/Jan/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>1-11-56</u>	<u>Int. Calvary</u>	<u>Forestville Md.</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>1/9/56</u>	<u>Rever. Mr. Thompson</u>	<u>Robert A. Mattingly</u>	<u>131-N. St. J.E. Wash. D.C.</u>

THE UNIVERSITY OF CHICAGO

1928

850

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>New York</u>	COUNTY <u>--</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Bethesda</u>	LENGTH OF STAY (In this place) <u>91 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Scarsdale</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center Bethesda, Maryland</u>		STREET ADDRESS (If rural give location) <u>53 Fayette Road</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Fred erick Norman Polangin</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan. 3, 1956</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Feb. 13, 1913</u>
9. AGE last birthday: <u>42</u> yrs.		IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Advertising</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Advertising</u>	
11. BIRTHPLACE (State or foreign country): <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY: <u>U. S. A.</u>	
13. FATHER'S NAME: <u>William Polangin</u>		14. MOTHER'S MAIDEN NAME: <u>Sophie Cransfield</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes W.W. II</u>		16. SOCIAL SECURITY No. <u>Not available</u>	
17. INFORMANT & ADDRESS: <u>The Medical Record, The Clinical Center</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Sepsis & gas gangrene of internal organs</u>			
ANTECEDENT CAUSE (B) <u>Acute appendicitis & localized peritonitis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Acute granulocytic leukemia</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>3. none</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Oct. 4, 1955</u> , to <u>Jan. 3, 1956</u> , that I last saw the deceased alive on <u>Jan. 3, 1956</u> , and that death occurred at <u>8:40 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Robert J. Levine</u>		M. D. ADDRESS DATE SIGNED <u>1/3/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial-Transit</u>		DATE THEREOF <u>1-4-56</u>	
NAME OF CEMETERY OR CREMATORY <u>Beth Isreal</u>		LOCATION (City, town, or county) (State) <u>Mercer Co. Pennsylvania</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/4/56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	
24. FUNERAL DIRECTOR <u>Robert R. Campbell</u>		ADDRESS <u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 1 1900
U. S. DEPT. OF AGRICULTURE

851

CERTIFICATE OF DEATH

Reg. Dist. No. 216.....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Prince Georges</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Bethesda</u>		LENGTH OF STAY (In this place) <u>1 day</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Brentwood, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center Bethesda, Md.</u>				STREET ADDRESS (If rural give location) <u>4309 39th Place</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Louis Anthony Post, Jr.</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan. 26, 19 56</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>March 28, 1910</u>	9. AGE last birthday: <u>45</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Warehouse Mgr. Warehousing</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Warehousing</u>		11. BIRTHPLACE (State or foreign country): <u>Mass.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME: <u>Louis A. Post</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Emerson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give year or dates of service) <u>Yes W.W. II</u>				16. SOCIAL SECURITY NO. <u>Not available</u>		17. INFORMANT & ADDRESS: <u>The Medical Record, The Clinical Center</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>						<u>3 hours.</u>	
ANTECEDENT CAUSE (B) <u>Acute myelogenous leukemia</u>						<u>1 mo</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Acute myelogenous leukemia</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>None</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.			
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? <u>Bethesda, Md.</u>							
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Jan. 26, 1956</u>				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>			
21F. HOW DID INJURY OCCUR? <u>None</u>							
22. I hereby certify that I attended the deceased from <u>Jan. 25, 1956</u> , to <u>Jan. 26, 19 56</u> that I last saw the deceased alive on <u>Jan. 26</u> , 1956, and that death occurred at <u>11:12 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Bernard R. Landon</u>				ADDRESS <u>M. D. The Clinical Center, NIH Bethesda, Md.</u> DATE SIGNED <u>1/27/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>				DATE THEREOF <u>1/30/1956</u>			
NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATI CON</u>				LOCATION (City, town, or county) (State) <u>ARLINGTON Virginia</u>			
DATE REC'D BY LOCAL REGISTRAR <u>1-30-56</u>				REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			
24. FUNERAL DIRECTOR <u>W. W. CHAMBERS Co - Riverdale, Md</u>				ADDRESS			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

189

189

852

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Louisiana</u>	COUNTY <u>--</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda</u>	LENGTH OF STAY (In this place) <u>39 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>New Orleans</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center Bethesda, Maryland</u>		STREET ADDRESS (If rural give location) <u>17 North Hawk Street</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>Rose</u>	(Middle) <u>Ann</u>	(Last) <u>Randazzo</u>	(Month) <u>January</u> (Day) <u>5</u> (Year) <u>1956</u>
(Type or Print)			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>April 30, 1913</u>
			9. AGE last birthday <u>42 yrs.</u>
			IF UNDER 1 YEAR: Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Clerk</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>S.W. Bell Telephone</u>	
11. BIRTHPLACE (State or foreign country): <u>Louisiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Vincent Randazzo</u>		14. MOTHER'S MAIDEN NAME: <u>Marie DiMarco</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Not available</u>	
17. INFORMANT & ADDRESS: <u>The Medical Record, The Clinical Center</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<u>170X</u>			
IMMEDIATE CAUSE (A) <u>Wild spread metastases</u>			
ANTECEDENT CAUSE (B) <u>Carcinoma of the breast, metastatic to</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Ulcer ulcer in 1st part of</u>			
<u>colonium.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov. 27, 1955 to Jan. 5, 1956, that I last saw the deceased alive on Jan. 5, 1956, and that death occurred at 9:47 P.M. from the causes and on the date stated above.			
SIGNATURE <u>Robert M. Campbell</u>		DATE SIGNED <u>Jan. 5, 1956</u>	
M. D. <u>The Clinical Center, NIH, Bethesda, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<u>Burial-Transit</u>		<u>1-7-56</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Metairie</u>		<u>New Orleans, La.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/9/56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	
FUNERAL DIRECTOR <u>Robert M. Campbell</u>		ADDRESS <u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

U. S. A. 1911

730
CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	OR TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. Sanitarium Hospital</u>		STREET ADDRESS (If rural give location) <u>509 Philadelphia</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>Jessie</u>	(Middle) <u>Everett</u>	(Last) <u>Reader</u>	(Month) <u>1</u> (Day) <u>1</u> (Year) <u>1956</u>
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Caucasian</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>W. Dow.</u>	8. DATE OF BIRTH: <u>F. 27-27</u>
9. AGE last birthday: <u>28</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY: <u>—</u>	
11. BIRTHPLACE (State or foreign country): <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY: <u>—</u>	
13. FATHER'S NAME: <u>Abram Baker</u>		14. MOTHER'S MAIDEN NAME: <u>Hucy Everett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT & ADDRESS: <u>Hospital Records</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE <u>Massive Myocardial Infarction</u>			
(B) ANTECEDENT CAUSE (8) <u>—</u>			
(C) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>—</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>—</u>			
19A. DATE OF OPERATION: <u>—</u>		19B. MAJOR FINDINGS OF OPERATION <u>—</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, office bldg., etc.) OF INJURY <u>—</u>	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? <u>—</u>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>—</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR? <u>—</u>			
22. I hereby certify that I attended the deceased from <u>8/12</u> , 19 <u>47</u> to <u>1/1</u> , 19 <u>56</u> that I last saw the deceased alive on <u>12/31</u> , 19 <u>55</u> and that death occurred at <u>6:25 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Dean Stauding</u>		DATE SIGNED <u>Jan. 1, 1956</u>	
M. D. <u>113 Carroll St NW Wash DC</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		DATE THEREOF <u>JAN. 3, 1956</u>	
NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		LOCATION (City, town, county) (State) <u>Penn Co. Extended Pr Geo Co., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Jan 1-1956</u>		REGISTRAR'S SIGNATURE <u>J. Nelson Codd</u>	
24. FUNERAL DIRECTOR <u>J. Arthur Walters</u>		ADDRESS <u>254 Carroll St NW DC</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1056 4 1
1056 4 1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. **00827**
 No. **216**

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Montgomery	MARYLAND	STATE Maryland	COUNTY Montgomery
CITY (If outside corporate limits, write RURAL OR and give nearest town) Bethesda	LENGTH OF STAY (in this place) 4 years	CITY (If outside corporate limits write RURAL and give nearest town) Bethesda	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 9207 Bulls Run Parkway		STREET ADDRESS (If rural, give location) 9207 Bulls Run Parkway	
3. NAME OF DECEASED: (Type or Print) Robert (First) R. (Middle) Redfield (Last)		4. DATE OF DEATH January 2 19 56	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH: July 7, 1923
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Physician		10b. KIND OF BUSINESS OR INDUSTRY: Medical	9. AGE last birthday: 32 yrs. 5 Months 25 Days
11. BIRTHPLACE (State or foreign country): Ogden Utah		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Cleveland Redfield		14. MOTHER'S MAIDEN NAME: Emma Stone	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: None	
17. INFORMANT & ADDRESS: Elizabeth G. Redfield- Same Item #2			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
Immediate cause (a) Respiratory Depression and Failure	DUE TO	8 hr.
Antecedent cause(s) (b) Ingestion of Depressant Drugs	DUE TO	12 hr.
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)		

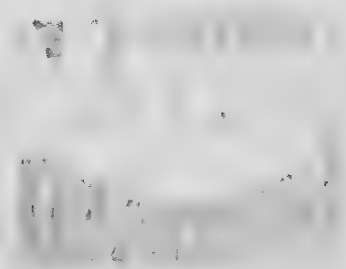
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Home	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY Jan. 2 - 1956 4 P.M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Type not yet determined

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

SIGNATURE **John S. Ball** CHIEF MEDICAL EXAMINER ☐ DATE SIGNED **2 Jan 1956**
 DEPUTY MEDICAL EXAMINER ☐
 M. D. ASSISTANT MEDICAL EXAM. ☒

23. BURIAL, CREMATION, REMOVAL (Specify): Burial-transit	DATE THEREOF 1/3/56	NAME OF CEMETERY OR CREMATORY Ogden	LOCATION (City, town, or county) (State) Weber Co. Utah
DATE REC'D BY LOCAL REG. 1/4/56	REGISTRAR'S SIGNATURE Bessie M. Houston	24. FUNERAL DIRECTOR Robert D. Humphrey ADDRESS Bethesda, Maryland	

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



854
CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Montgomery</i>	MARYLAND	STATE <i>Md.</i>	COUNTY <i>Montgomery</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Kensington Md.</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Kensington Md.</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>3104 Jennings Road</i>		STREET ADDRESS (If rural, give location) <i>3104 Jennings Road</i>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <i>Mary</i>	(Middle) <i>A.</i>	(Last) <i>Reed</i>	(Month) <i>Jan</i> (Day) <i>11</i> (Year) <i>1956</i>
5. SEX: <i>F</i>	6. COLOR OR RACE: <i>M</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>MARRIED</i>	8. DATE OF BIRTH: <i>June 16, 1884</i>
9. AGE last birthday <i>71</i> yrs		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>own home</i>	
11. BIRTHPLACE (State or foreign country): <i>Austria</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>unknown</i>		14. MOTHER'S MAIDEN NAME: <i>unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>no</i> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT & ADDRESS: <i>Mr. Paul M. Reed, 3104 Jennings Road Kensington, Maryland</i>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE <i>420.1</i>		(A) <i>CORONARY Occlusion</i>	
ANTECEDENT CAUSE (B)		DUE TO <i>ARTERIO Sclerosis</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>None</i>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) OF INJURY		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Jan 10</i> , 1956, to <i>Jan 11</i> , 1956, that I last saw the deceased alive on <i>Jan 10</i> , 1956, and that death occurred at <i>6:00 AM</i> , from the causes and on the date stated above.			
SIGNATURE <i>Michael R. Dolbrige</i>		DATE SIGNED <i>Jan 11, 1956</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>1/13/56</i>	
NAME OF CEMETERY OR CREMATORY <i>Arlington National Cemetery</i>		LOCATION (City, town, or county) (State) <i>Arlington, Virginia</i>	
DATE REC'D BY LOCAL REGISTRAR <i>1-13-56</i>		REGISTRAR'S SIGNATURE <i>Francis J. Feller</i>	
24. FUNERAL DIRECTOR <i>Walter E. Humphrey</i>		ADDRESS <i>8434 Ga. Ave. Silver Spring, Md.</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Jan 11, 1956 -

Coroner notified: No autopsy to be performed

in office of

BUREAU V. S.

JAN 17 1956

RECEIVED

855

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Virginia</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bethesda</u>	LENGTH OF STAY (in this place) <u>58 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Norfolk</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center Bethesda, Maryland</u>		STREET ADDRESS (If rural give location) <u>879 Washington Avenue</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Emma</u> <u>--</u> <u>Reid</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan. 3, 1956</u>	
5. SEX: <u>F.</u>	6. COLOR OR RACE: <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>June 5, 1919</u>
9. AGE last birthday <u>36</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country): <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Jack Morrison</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Bloom</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Not available</u>	
17. INFORMANT & ADDRESS: <u>The Medical Record, The Clinical Center</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
(A) IMMEDIATE CAUSE <u>Jejunal obstruction</u>			<u>9 days</u>
(B) ANTECEDENT CAUSE (S) <u>Peritoneal adhesions</u>			<u>2 wks</u>
(C) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>Carcinoma of cervix & metastases</u>			<u>2 1/2 yrs</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>3 12/10/55</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Metastatic tumor liver. Cystectomy performed</u>	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 6 1955</u> , to <u>Jan. 3, 1956</u> that I last saw the deceased alive on <u>Jan. 3, 1956</u> , and that death occurred at <u>10:45 M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Arthur George Ship</u> M.D.		DATE SIGNED <u>1/5/56</u>	
23. BURIAL CREMATION, REMOVAL (SPECIFY) <u>1-6-56</u>		NAME OF CEMETERY OR CREMATORY <u>Hamlet</u> LOCATION (City, town, or county) (State) <u>N.C.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/4/56</u>		24. FUNERAL DIRECTOR <u>FRANZ'S FUNERAL HOME</u> ADDRESS <u>389 P.I.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

U.S. DEPARTMENT OF AGRICULTURE

DEPARTMENT OF AGRICULTURE

856 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY	Montgomery	STATE	Maryland
CITY (If outside corporate limits, write RURAL and give nearest town)	Bethesda Rural	COUNTY	
TOWN		CITY (If outside corporate limits, write RURAL and give nearest town)	Cheverly
HOSPITAL OR INSTITUTION OR STREET ADDRESS	U. S. Naval Hospital	STREET ADDRESS	6103 Kilmer Street

3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First)	(Middle)	(Month)	(Day)
Jennie	Stephanie	January	13
(Type or Print)	RHODES	(Year)	1956
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:
Female	White	Widowed	3-15-86
9. AGE last birthday		10. IF UNDER 1 YEAR	
69 yrs.		Months	Days
		Hours	Min.

11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Michigan	US

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Frederick WILDMAN	Margaret WILSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT'S ADDRESS
No	None	Son William J. RHODES Same as above

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE	(A) Cause of Death	6 days
ANTECEDENT CAUSE (S)	DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(B) DUE TO	
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Rheumatic Heart Disease		yes

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
2		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9 Jan, 1956, to 13 Jan, 1956, that I last saw the deceased alive on 13 Jan, 1956, and that death occurred at 1:15 A.M. from the causes and on the date stated above.	
SIGNATURE	DATE SIGNED
A. J. CAPPELLI	
A. J. CAPPELLI LCDR, MC, USN U. S. Naval Hospital, NMM, Bethesda, Maryland	

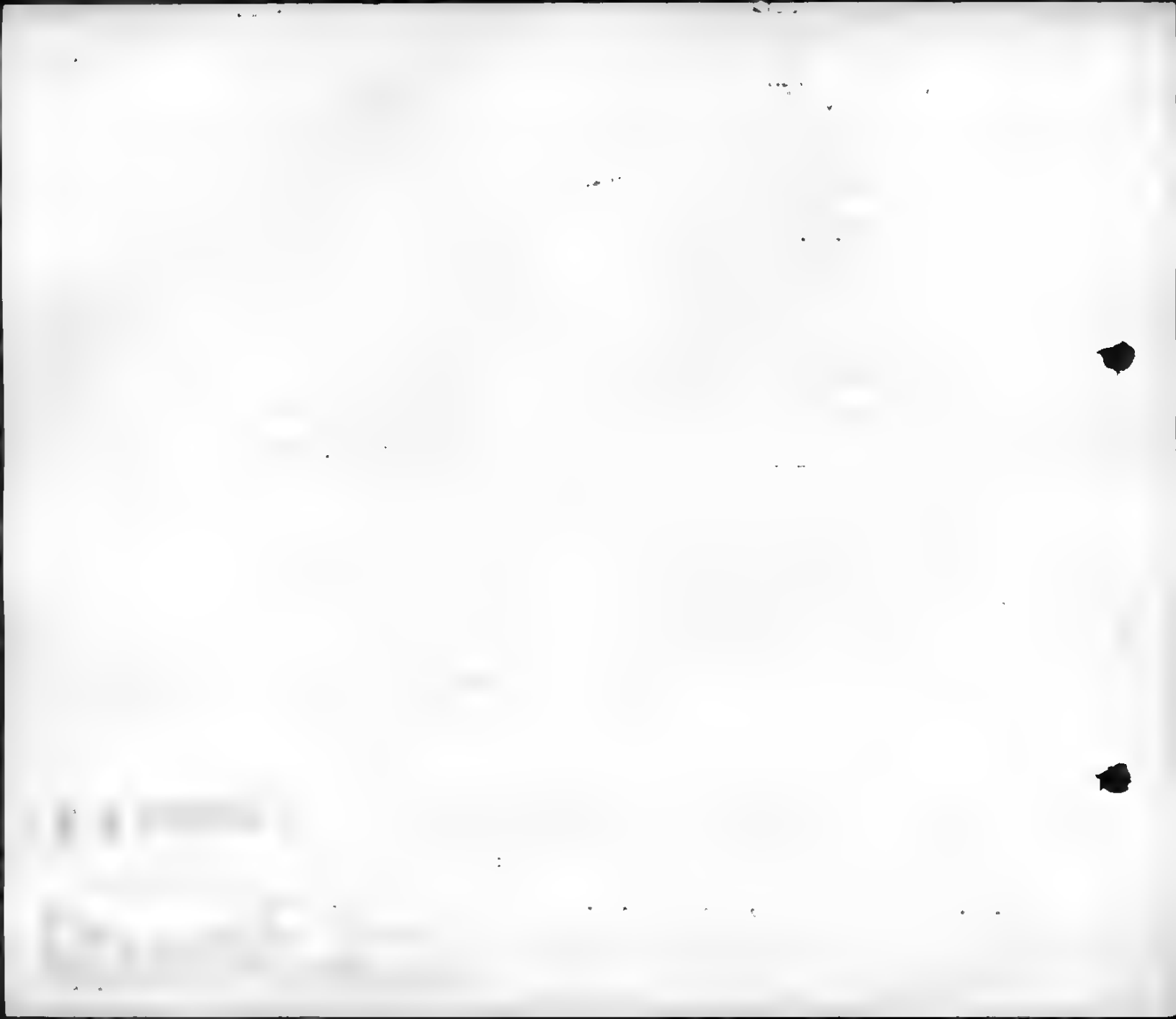
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	16 Jan 1956	Arlington National Cemetery	Arlington, Virginia

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL HOME ADDRESS
13 Jan 1956	Mary E. Caspary	3831 Georgia Avenue, N.W. Wash D.C.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Dist. Col.</u> COUNTY			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Washington</u>			
TOWN <u>Rockville</u>		<u>4 days</u>		STREET ADDRESS (If rural, give location) <u>4442 Mass. Ave. N.W.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8 Manakee Street</u>							
3. NAME OF DECEASED: (First) <u>Mary</u>		(Middle) <u>Elizabeth</u>		(Last) <u>RICKETTS</u>		4. DATE OF DEATH: January 11 19 56	
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>		8. DATE OF BIRTH: <u>Aug. 27, 1873</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Housework</u>		11. BIRTHPLACE (State or foreign country): <u>Rockville Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>James F. Gettings</u>				14. MOTHER'S MAIDEN NAME: <u>Frances Bean</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u>		16. SOCIAL SECURITY No.: <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Florence Lovie Ricketts 10420 Haywood Dr. Silver spring, Md.</u>			

18. MEDICAL CERTIFICATION		
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cerebral hemorrhage</u>		<u>4 days</u>
Antecedent cause(s) (b) <u>Hypertensive heart disease</u>		<u>4-5 yrs.</u>
DUE TO (c) <u>Generalized arteriosclerosis</u>		<u>20 yrs.</u>
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1/7</u> , to <u>1/11</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>1/10</u> , 19 <u>55</u> , and that death occurred at <u>6:30 p.m.</u> , from the causes and on the date stated above.					
SIGNATURE <u>M. G. Hall</u>		(DEGREE OR TITLE) <u>M.D.</u>		ADDRESS <u>Rockville, Md.</u> DATE SIGNED <u>1/11/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>1-15-1956</u>		NAME OF CEMETERY OR CREMATORY <u>Rockville Union</u> LOCATION (City, town, or county) (State) <u>Rockville Maryland</u>	
DATE REC'D BY LOCAL REG. <u>1/13/56</u>		REGISTRAR'S SIGNATURE <u>Laurel H. Bagley</u>		24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u> ADDRESS <u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DEPARTMENT OF THE ARMY

101

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00832

223

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Montgomery</u> MARYLAND			STATE <u>Maryland</u> COUNTY <u>Montgomery</u>		
CITY (If outside corporate limits, write RURAL and give nearest town) <u>17 TOWN Takoma Park</u>			CITY (If outside corporate limits, write RURAL and give nearest town) <u>OR TOWN Takoma Park</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Sanitarium and Hospital</u>			STREET ADDRESS (If rural give location) <u>8113 Carroll Avenue</u>		
3. NAME OF DECEASED (Type or Print)			4. DATE (Month) (Day) (Year) OF DEATH		
(First) <u>Florence</u> (Middle) <u>Isabel</u> (Last) <u>Robeson</u>			<u>Jan 6 1956</u>		
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR
<u>Female</u>	<u>Cauc.</u>	<u>Widow</u>	<u>9-14-1880</u>	<u>75</u> yrs.	Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Govt Clerk</u>			10B. KIND OF BUSINESS OR INDUSTRY:		
11. BIRTHPLACE (State or foreign country): <u>Dist. of Columbia</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME: <u>John Glick</u>			14. MOTHER'S MAIDEN NAME: <u>Mary Wambold</u>		
15. WAS DECEASED EVER IN U.S. ARMY OR NAVY? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO.		
17. INFORMANT & ADDRESS: <u>Hospital Records</u>					

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>Embolic, cerebral artery</u>		<u>17 days</u>
DUE TO ANTECEDENT CAUSE (B) <u>Myocardial infarction, left ventricle of heart</u>		<u>several months</u>
DUE TO (C) <u>Healing infarct of myocardium, apex left ventricle</u>		<u>18 months</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION: <u>2</u>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, etc.) OF INJURY	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from December 20, 1955, to January 6, 1956, that I last saw the deceased alive on January 6, 1956, and that death occurred at 12 P M, from the causes and on the date stated above.

SIGNATURE <u>Robbin M.D.</u>	ADDRESS <u>1200 Lebron Street Silver Spring, Md.</u>	DATE SIGNED <u>Jan 6, 1956</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>Jan 9-1956</u>	NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem</u>
		LOCATION (City, town, or county) (State) <u>Rivers George Co Md</u>
DATE REC'D BY LOCAL REGISTRAR <u>Jan. 6-1956</u>	REGISTRAR'S SIGNATURE <u>John Dobb</u>	24. FUNERAL DIRECTOR <u>The S.H. Hines Co</u> ADDRESS <u>2901-14th St. N.W. D.C.</u>

8-3 10113

10113

857

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
TOWN <u>Bethesda</u>		<u>4.5 hours</u>		TOWN <u>Silver Spring</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>				STREET ADDRESS (If rural give location) <u>2407 Lindell Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH			
<u>Louise Ellen Robinson</u>				<u>1 - 7 1956</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>Widow</u>	<u>8/25/88</u>	<u>67</u> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Salisbury retired</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
13. FATHER'S NAME: <u>William F. Fowler</u>				14. MOTHER'S MAIDEN NAME:			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Charles C Robinson 317 Woodburn Rd. Rockville, Md.</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE							
(A) <u>Coronary</u>							
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B) <u>Diabetes</u>							
(C) <u>Generalized arteriosclerosis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:			19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>Sept. 1, 1955</u> , to <u>Jan 7, 1956</u> , that I last saw the deceased alive on <u>Jan. 6, 1956</u> , and that death occurred at <u>12:35 PM</u> , from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>Walter A. Angerine</u>		<u>M. D. 6300-13th St. N.W. Wash. D.C.</u>		<u>Jan. 7, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10-1-56</u>		<u>Lawson Park Cem.</u>		<u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		FUNERAL DIRECTOR		ADDRESS	
<u>1/9/56</u>		<u>Bessie M. Thompson</u>		<u>J. Arthur Walters</u>		<u>254 Carroll St. N.E.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

FORM V. 2

853

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Bethesda</u>		<u>2 1/2</u> yrs.		TOWN <u>Bethesda</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4620 Drummond Ave.</u>				STREET ADDRESS (If rural give location) <u>4620 Drummond Ave.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
Clarence P. Rowland				OF DEATH: Jan. 20, 19 56			
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH: Oct. 16, 1882	
				9. AGE last birthday <u>73</u> yrs.		10. IF UNDER 1 YEAR: Months <u>3</u> Days <u>4</u> Hours <u>4</u> Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Bank Officer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Retired</u>		11. BIRTHPLACE (State or foreign country): <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>John S. Rowland</u>				14. MOTHER'S MAIDEN NAME: <u>Annie E. Pidgeon</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>180-12-0116</u>		17. INFORMANT & ADDRESS: <u>William F. Rowland</u> <u>4620 Drummond Ave, Bethesda, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>CEREBRAL HEMORRHAGE</u>						<u>10 1/2 MIN.</u>	
DUE TO							
ANTECEDENT CAUSE (B) <u>GENERALIZED ARTERIO SCLEROSIS</u>						<u>10 Yrs</u>	
DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7 JUNE</u> , 19 <u>55</u> , to <u>20 JAN.</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12 JANUARY</u> , 19 <u>56</u> , and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Frederick W. Coe</u>				ADDRESS <u>M.D. 1835 Eye St. N.W. Wash. D.C.</u>		DATE SIGNED <u>21 Jan. 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial-Transit</u>		<u>1-24-56</u>		<u>Fernwood Cemetery</u>		<u>Delaware Co. Pa.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-31-56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

FEB

INDONESIA

859 CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Olney</u>		LENGTH OF STAY (in this place) <u>3 mos. 3 wks</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Laytonsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Montgomery County General Hospital, Inc.</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(First) <u>Willis</u>		(Middle) <u>Burnside</u>		(Last) <u>Runkles</u>		OF DEATH: <u>January 1</u> 19 <u>56</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>10/26/64</u>	9. AGE last birthday <u>91</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>none</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>none</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME: <u>Basil Runkles</u>			
14. MOTHER'S MAIDEN NAME: <u>Mary Ellen Mentzer</u>				15. INFORMANT & ADDRESS: <u>Hospital Records</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.): <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>			
17. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Senility</u>							
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>Nov.</u> , 19 <u>55</u> , to <u>Jan. 1</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan. 1</u> , 19 <u>56</u> , and that death occurred at <u>2:26 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Frank Schumacher</u>				ADDRESS <u>Frederick, Md.</u>		DATE SIGNED <u>Jan. 9, 56</u>	
M.D. <u>Frederick, Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan 4, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Prospect</u>		LOCATION (City, town, or county) (State) <u>Frederick, Co. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-4-56</u>		REGISTRAR'S SIGNATURE <u>Bertrude B Lawler</u>		24. FUNERAL DIRECTOR <u>Roy W Barber</u>		ADDRESS <u>Laytonville 1829</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

U. S. A.

DEAD

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

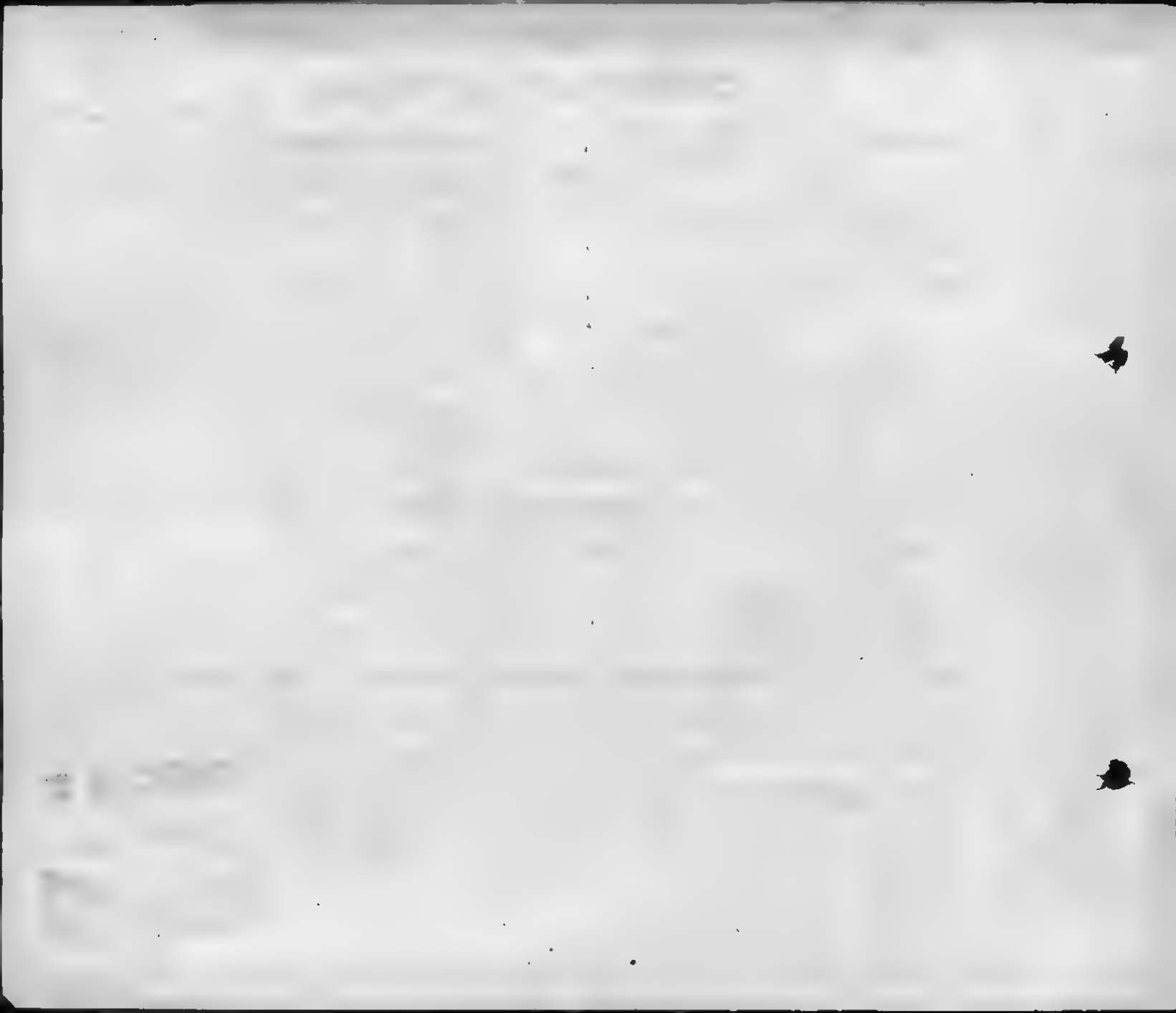
860

CERTIFICATE OF DEATH

00836

Reg. Dist. No. 212

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
X TOWN <u>Boyd's - RFD</u>		<u>30 yrs</u>		TOWN <u>Boyd's - RFD</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Harry</u> (Middle) <u>Randolph</u> (Last) <u>Savage</u>				(Month) <u>Jan</u> (Day) <u>22</u> (Year) <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>M</u>	<u>White</u>	<u>Married</u>	<u>Feb-22-1879</u>	<u>76</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Farmer (Owner)</u>				<u>Virginia</u>		<u>US</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>George D. Savage</u>				<u>Martina E. Ballenger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Leroy Savage - Boyd's, Md</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						<u>24 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral arteriosclerosis</u>						<u>2 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>None</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 1</u> , 19 <u>56</u> , to <u>Jan 22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 22</u> , 19 <u>56</u> , and that death occurred at <u>3:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Vernon E. Hartman</u>				ADDRESS (Street, city, town, state) <u>Germania, Md</u>		DATE SIGNED <u>Jan 22, 56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1/25/56</u>		<u>Monocacy</u>		<u>Beallsville, Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Jan 23/56</u>		<u>Charles E. Egan</u>		<u>William B. Hilton</u>		<u>Barnesville, Md</u>	



732

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Takoma Park</u>	LENGTH OF STAY (In this place) <u>3 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rockville</u>	<u>26</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Sanitarium + Hospital 5821 Crawford Drive</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>Gertrude</u>	(Middle) <u>Dale</u>	(Last) <u>Schroeder</u>	DEATH: <u>January 19 1956</u>
5. SEX:		6. DATE OF BIRTH:	
F <u>Wife</u>		<u>Sept 26, 1913</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>		8. AGE last birthday IF UNDER 1 YEAR IF UNDER 24 HRS.	
		<u>42 yrs.</u> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Hswt</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>at home</u>	
11. BIRTHPLACE (State or foreign country): <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>William J. Dale</u>		14. MOTHER'S MAIDEN NAME: <u>Lillian McCurdy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>Unknown</u>	
17. INFORMANT & ADDRESS: <u>Mr. Louis W. Schroeder - same address.</u>			

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
IMMEDIATE CAUSE <u>581.1</u>	(A) <u>Lower nephron nephrosis</u>	
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>322.0</u>	(B) <u>Acute Alcoholic</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Leucemia, carcinoma</u>		

19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan 16, 1956</u> , to <u>Jan 19, 1956</u> , that I last saw the deceased alive on <u>Jan 19, 1956</u> , and that death occurred at <u>P.M.</u> , from the causes and on the date stated above.					
SIGNATURE <u>Raymond O'Leary</u>		M.D. <u>7600 Capital Blvd. N.W.</u>		DATE SIGNED <u>Jan 20/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		DATE THEREOF <u>1/24/56</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	
LOCATION (City, town, or county) (State) <u>Switzland Md.</u>		DATE REC'D BY LOCAL REGISTRAR <u>Jan 21/56</u>		REGISTRAR'S SIGNATURE <u>W. W. Chambers</u>	
24. FUNERAL DIRECTOR <u>W. W. Chambers</u>		ADDRESS <u>3072 N. St. N.W.</u>		CITY <u>Wash. D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



11

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH: 861				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Montgomery		MARYLAND		STATE Maryland		COUNTY Prince George's	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Bethesda Rural		LENGTH OF STAY (in this place) 9 hrs 29 min		CITY (If outside corporate limits, write RURAL and give nearest town) Takoma Park			
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital				STREET ADDRESS (If rural give location) 6913 Westmoreland Avenue			
3. NAME OF DECEASED: (First) Lorraine		(Middle) Dawn		(Last) SCHUBERT		4. DATE (Month) (Day) (Year) OF DEATH: January 8 19 56	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: 1-8-56		9. AGE last birthday: 9 yrs.		IF UNDER 1 YEAR Months 9 Days 29
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None			10B. KIND OF BUSINESS OR INDUSTRY: None		11. BIRTHPLACE (State or foreign country): Bethesda, Maryland		12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME: Harvey C. SCHUBERT				14. MOTHER'S MAIDEN NAME: Margaret J. MEADOWS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) - -			16. SOCIAL SECURITY NO. - -		17. INFORMANT & ADDRESS: Father Harvey C. SCHUBERT Same as above		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Congenital Atelectasis						9 1/2 hrs.	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:			19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from 8 Jan., 19 56 to 8 Jan., 19 56 that I last saw the deceased alive on 8 Jan., 19 56 and that death occurred at 9:30P M, from the causes and on the date stated above.							
SIGNATURE George J.A. Magnant				ADDRESS		DATE SIGNED	
G. J.A. MAGNANT LT, MC, USN U. S. Naval Hospital, NMMC, Bethesda, Maryland							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		13 Jan 1956		Arlington National Cemetery		Arlington, Virginia	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
9 Jan 1956		Mary E. Ganssely		R. A. Humphrey Funeral Home		7557 Wisconsin Avenue, Bethesda, Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DOMINGO A. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 216

862

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u> MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montg.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Chevy Chase</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5300 Saratoga Ave</u>		STREET ADDRESS (If rural give location) <u>5300 Saratoga Avenue</u>	
3. NAME OF DECEASED: (Type or Print) <u>Leon Perry Shoemaker</u>		4. DATE OF DEATH: (Month) <u>January</u> (Day) <u>3</u> (Year) <u>1956</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>10-8-1891</u>
9. AGE last birthday: <u>64</u> yrs. <u>2</u> Months <u>25</u> Days <u></u> Hours <u></u> Min.		10. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Ret. Civil Eng.</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13. FATHER'S NAME: <u>William Shoemaker</u>		14. MOTHER'S MAIDEN NAME: <u>Sarah Eliza Perry</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO.: <u>None</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Rudolph J. Bopp</u>		<u>5300 Saratoga Ave. Ch. Ch. Md.</u>	

18. MEDICAL CERTIFICATION		Interval Between Onset And Death	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Gastric hemorrhages</u>		<u>24 hours</u>	
Antecedent causes (s) (b) <u>Congestive heart failure</u>		<u>2 days</u>	
(c) <u>Coronary artery disease</u>		<u>1 weeks</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? <u>Yes</u> <input type="checkbox"/> <u>No</u> <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>-</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u></u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u></u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
HOW DID INJURY OCCUR? <u></u>			
22. I hereby certify that I attended the deceased from <u>12-29-1955</u> to <u>Jan 3, 1956</u> , that I last saw the deceased alive on <u>Jan 3, 1956</u> , and that death occurred at <u>9:45 AM</u> from the causes and on the date stated above.			
SIGNATURE <u>Roger Kutz M.D.</u>		DATE SIGNED <u>Jan 3 1956</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>1-6-1956</u>	
NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		LOCATION (City, town, or county) <u>Rockville Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/4/56</u>		REGISTRAR'S SIGNATURE <u>Bennie M. Thompson</u>	
24. FUNERAL DIRECTOR <u>Robert C. Humphrey</u>		ADDRESS <u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BRIDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

EDWARD V. S.

JAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

863

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

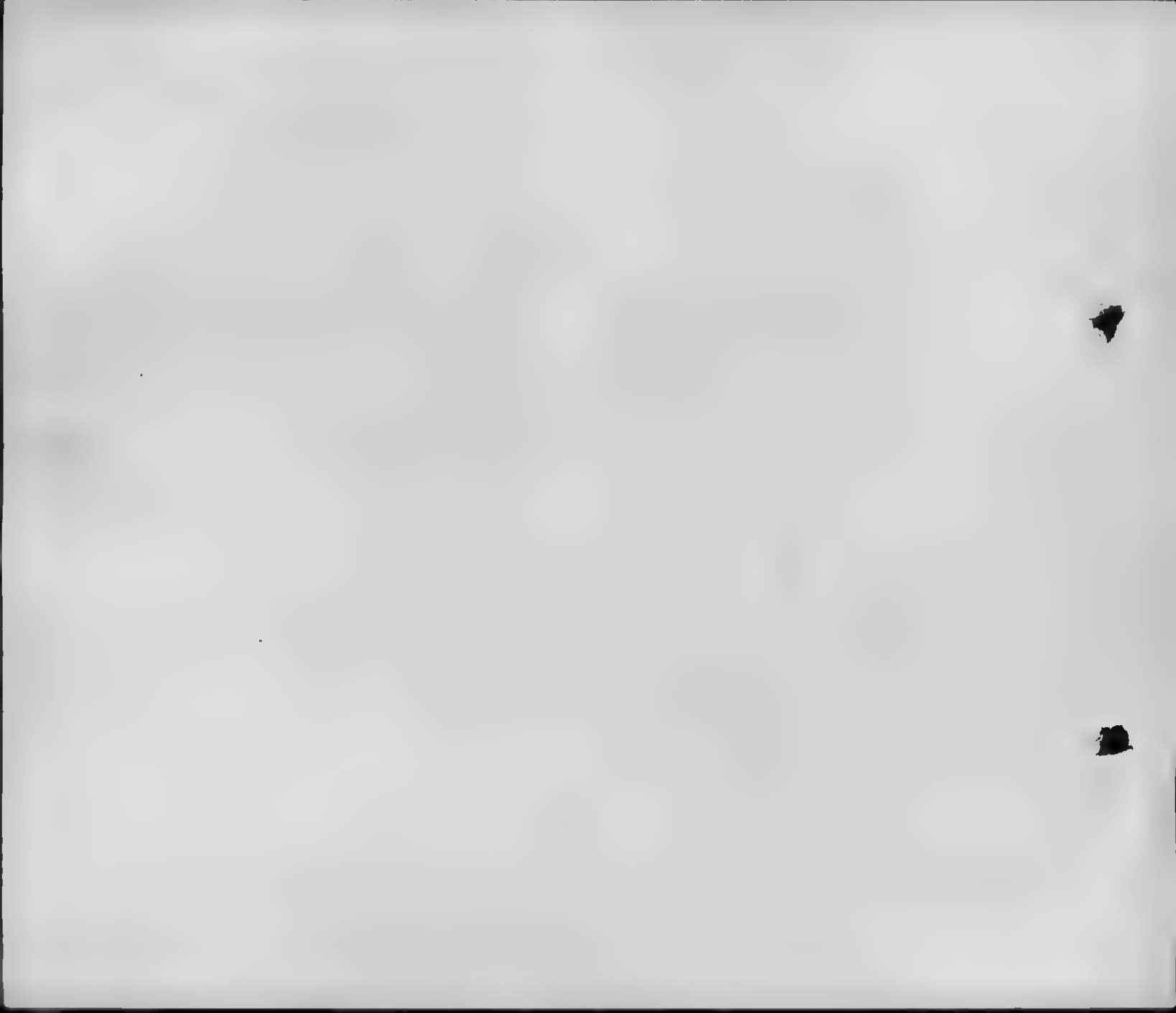
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. 00841

No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>...</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Silver Springs</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) <u>Silver Springs</u>		OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2223 Osborn Drive</u>				STREET ADDRESS (If rural, give location) <u>2223 Osborn Drive</u>			
3. NAME OF DECEASED: (First) <u>Jacob</u> (Middle) (Last) <u>Silverman</u>				4. DATE OF DEATH (Month) <u>Jan</u> (Day) <u>7</u> (Year) <u>1956</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W-</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>Widowed</u>		8. DATE OF BIRTH:	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Ready to wear</u>		9. AGE last birthday: <u>85</u> yrs.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. BIRTHPLACE (State or foreign country): <u>Lith</u>				13. FATHER'S NAME: <u>Simon</u>			
14. MOTHER'S MAIDEN NAME: <u>Rachael</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			
16. SOCIAL SECURITY No.:				17. INFORMANT & ADDRESS: <u>Marvin Conn - Same</u>			

18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: Immediate cause (a) <u>Starvation</u> DUE TO Antecedent cause(s) (b) <u>Carcinoma of Stomach</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>Six Months</u>
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH			
19a. DATE OF OPERATION: <u>9 Nov. 1955</u>		19b. MAJOR FINDING OF OPERATION: <u>Carcinoma of Stomach</u>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town)	(County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . SIGNATURE <u>John S. Ball</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Jan 1956</u> M. D. DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF: <u>1-11-56</u>	NAME OF CEMETERY OR CREMATORY: <u>Ferning Run</u>	LOCATION (City, town, or county) (State): <u>Balto Md</u>
DATE REC'D BY LOCAL REG: <u>1/14/56</u>	REGISTRAR'S SIGNATURE: <u>...</u>	24. FUNERAL DIRECTOR: <u>Jack Lewis Inc 2100 Eutaw Pl</u>	



864

00841

Reg. Dist. 214

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY — <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Silver Spring</u>				TOWN <u>Silver Spring</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2208 Quinton Road</u>				STREET ADDRESS (If rural—give location) <u>2208 Quinton Road</u>			
3. NAME OF DECEASED: (First) <u>ARNOT</u> (Middle) <u>CRAWFORD</u> (Last) <u>SINE</u>		4. DATE OF DEATH (Month) <u>Jan.</u> (Day) <u>1</u> (Year) <u>19 56</u>					
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>3/23/14</u>	9. AGE last birthday: <u>41</u> yrs.	IF UNDER 1 YEAR: Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Officer - U. S. Army</u>			10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Hutchisin, Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>James S. Sine</u>				14. MOTHER'S MAIDEN NAME: <u>Margaret Buchan</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>no</u>		17. INFORMANT & ADDRESS: <u>Mrs. Rosa B. Sine, 2208 Quinton Road, Rosemary Hills, Silver Spring, Md.</u>			

18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Strangulation</u> DUE TO					<u>5 min.</u>
Antecedent cause(s) (b) _____ Diseases or conditions, if any, giving rise to the above cause DUE TO _____ stating underlying cause last (c) _____					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Home</u>		21c. (City or town) <u>Silver Spring</u> (County) <u>Montgomery</u> (State) <u>Md.</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY _____		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Hanging</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>John W. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED _____ DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <u>19 Jan 1956</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>1/5/56</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l. Cemetery</u> LOCATION (City, town, or county) <u>Arlington, Virginia</u> (State) _____	
DATE REC'D BY LOCAL REG. <u>Jan 5 1956</u>		REGISTRAR'S SIGNATURE <u>Frances C. Miller</u>		24. FUNERAL DIRECTOR <u>Warren E. Humphrey</u> ADDRESS <u>8434 Ga. Ave. Silver Spring, Md.</u>	

BUREAU A. S.

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RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00842
CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>One day</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Kensington</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center Bethesda, Maryland</u>				STREET ADDRESS (If rural give location) <u>3004 Oak Drive</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>Evangeline M. Smith</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan. 30, 19 56</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>15 Dec. 1907</u>	9. AGE last birthday <u>48</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>---</u>		11. BIRTHPLACE (State or foreign country): <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Eugene Paravano</u>				14. MOTHER'S MAIDEN NAME: <u>Pauline Johnstone</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Not available</u>		17. INFORMANT & ADDRESS: <u>The Medical Record, The Clinical Center</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE		(A) <u>Pulmonary infarction (multiple)</u>					
ANTECEDENT CAUSE (S)		(B) <u>Metastatic Adenocarcinoma Rt lung</u>					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>M.</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan. 30, 1956, to Jan. 30, 19 56 that I last saw the deceased alive on Jan. 30, 1956, and that death occurred at 7:50 P M, from the causes and on the date stated above.							
SIGNATURE <u>Ross M. Miller, Jr.</u>		M.D. <u>The Clinical Center, NIH, Bethesda, Md.</u>		DATE SIGNED <u>1-31-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		DATE THEREOF <u>Feb. 2, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		LOCATION (City, town, or county) (State) <u>Prince Geo. County, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2/1/56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>J. Arthur Walters</u>		ADDRESS <u>254 Carroll St NE</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



866

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u> MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> D.O.A.	STATE <u>Md.</u> COUNTY <u>Montgomery</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> X
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hosp.</u>		STREET ADDRESS (If rural give location) <u>5202 Glenwood Rd.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>George Oscar Smithson</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>Jan. 18 1956</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>	8. DATE OF BIRTH: <u>3-3-94</u>
9. AGE last birthday: <u>61</u> yrs. <u>10</u> Months <u>15</u> Days <u></u> Hours <u></u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Real Estate Self-emp.</u>	
11. BIRTHPLACE (State or foreign country): <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>George W.</u>		14. MOTHER'S MAIDEN NAME: <u>Josephine LaFontaine</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-01-2262</u>	
17. INFORMANT'S ADDRESS: <u>Frederick Smithson - Son</u> <u>3643 Yantess St N.W. Wash. D.C.</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>			
ANTECEDENT CAUSE (B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June 1947</u> to <u>Jan. 18, 1956</u> that I last saw the deceased alive on <u>Jan. 18, 1956</u> , and that death occurred at <u>2011 M.</u> from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>1-18-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-23-56</u>	
NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem</u>		LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/20/56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	
24. FUNERAL DIRECTOR <u>Robert A. Rumphrey</u>		ADDRESS <u>Bethesda</u>	

MARGIN RESERVED FOR BINDING

VS. A15 - 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

00844

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 24

1. PLACE OF DEATH:

COUNTY Montgomery MARYLAND
 CITY (If outside corporate limits, write OR and give nearest town) RURAL LENGTH OF STAY (in this place) 2 yrs
 TOWN Silver Spring
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 1580 East West Highway

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE md COUNTY Montg
 CITY (If outside corporate limits write RURAL and give nearest town) RURAL
 TOWN Silver Spring
 STREET ADDRESS (If rural, give location) 1580 East West Highway

3. NAME OF DECEASED:

(First) John (Middle) Harper (Last) Snapp
 (Type or Print)

4. DATE OF DEATH (Month) Jan (Day) 31 (Year) 1956

5. SEX:

male

6. COLOR OR RACE:

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

married

8. DATE OF BIRTH:

12-11-1891

9. AGE last birthday:

64 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Mln.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)

Photographer

10b. KIND OF BUSINESS OR INDUSTRY:

U.S. Dept of Int.

11. BIRTHPLACE (State or foreign country):

Wash. DC.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME:

John H. Snapp

14. MOTHER'S MAIDEN NAME:

Kathleen Keays

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS:

Mrs John H. Snapp - Same as John

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a)

DUE TO

Coronary occlusion

Antecedent cause(s)

(b)

DUE TO

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH

Sudden

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

Frank J. BroschartCHIEF MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

M. D.

ASSISTANT MEDICAL EXAM.

DATE SIGNED

1-31-56

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

1-31-56Frances Tellerof H. H. H. Co. Washington D.C.Washington D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

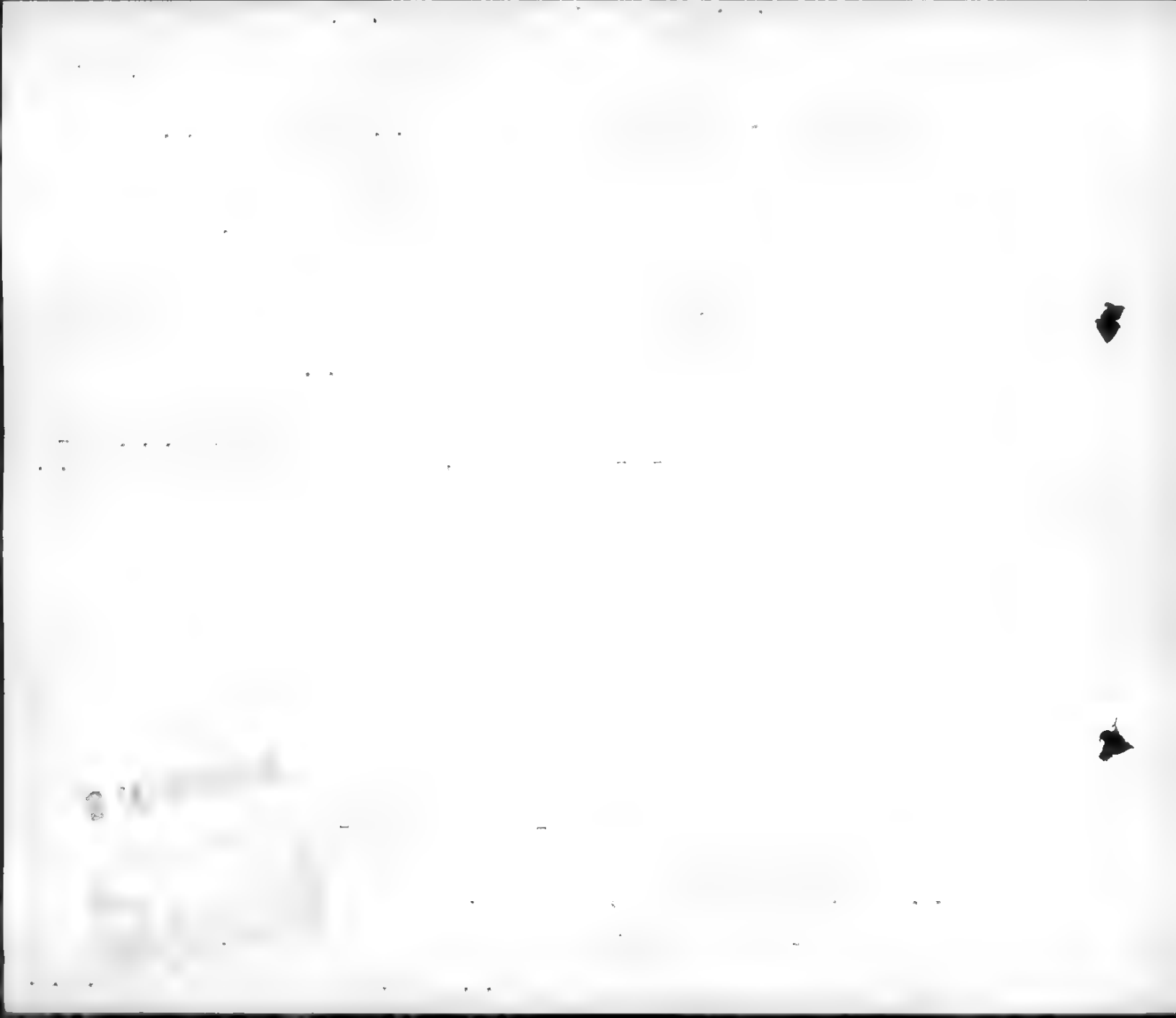
868

CERTIFICATE OF DEATH

Reg. Dist. No. 215

00845

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Montgomery	MARYLAND	STATE D.C.	COUNTY D.C.
CITY (If outside corporate limits, write RURAL OR and give nearest town) Bethesda Rural	LENGTH OF STAY (in this place) 2 mos; 26 dys	CITY (If outside corporate limits, write RURAL and give nearest town) District of Columbia	
HOSPITAL OR INSTITUTION OR STREET ADDRESS USNH, Bethesda		STREET ADDRESS (If rural give location) 3000 39th Street, NW	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year) OF DEATH:	
(First) Charles	(Middle) Dixon	(Last) SNIFFIN	
5. SEX: Male		6. COLOR OR RACE: Caucasian	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed		8. DATE OF BIRTH: 29 December 1887	
9. AGE last birthday 68 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country): Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME: Joseph SNIFFIN		14. MOTHER'S MAIDEN NAME: Elsie DULIN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give year or dates of service) WWI		16. SOCIAL SECURITY NO. 410-58-6305	
17. INFORMANT & ADDRESS: Sister: Mrs. T.B. SHOE-MAKER, 3000 39th Street, NW, Washington, D.C.		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) Carcinoma, Bronchogenic			
ANTECEDENT CAUSE (B) Undifferentiated with			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) extensive metastasis		7 mos	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While at work Not while at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 10-21-55 , to 1-17-56 , that I last saw the deceased alive on 1-17-56 , and that death occurred at 4:50a M, from the causes and on the date stated above.			
SIGNATURE LCDR J.W. FLYNN, MC USN, USNH, NMMC, Bethesda, Md.		DATE SIGNED 18 January 1956	
23. BURIAL CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 1-19-56	
NAME OF CEMETERY OR CREMATORY Arlington National		LOCATION (City, town, or county) (State) Arlington, Virginia	
DATE REC'D BY LOCAL REGISTRAR 1-18-56		24. FUNERAL DIRECTOR ADDRESS S.H. HINES, 2901 14th Street, NW, Wash., D.C.	



733
CERTIFICATE OF DEATH008463-
Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Chic</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
TOWN <u>TAKOMA PARK, MD</u>				TOWN <u>JACKSON</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>WASHINGTON SAN + HOSP</u>				STREET ADDRESS (If rural give location) <u>ROUTE #4</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
(Type or Print) <u>SANFORD REED SPELLMAN</u>				OF DEATH: <u>JAN 13 1956</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>MALE</u>	<u>WHITE</u>	<u>SINGLE</u>	<u>5-5-'46</u>	<u>61</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>GOLF WORKER</u>			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>CHIC</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMEA</u>
13. FATHER'S NAME: <u>HARLEY V. SPELLMAN</u>				14. MOTHER'S MAIDEN NAME: <u>LEFFIE LOUG</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>1008 Heronwell AVE Mrs. GLADYS HUSTLD T.I. MD. (SISTER)</u>		
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE			(A) <u>Carcinoma Head of Pancreas - metastases</u>				<u>3 mo.</u>
ANTECEDENT CAUSE (B)			DUE TO				
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			(B) DUE TO				
			(C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:			19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>Jan. 10, 1956</u> to <u>Jan. 13 1956</u> that I last saw the deceased alive on <u>Jan 13, 1956</u> , and that death occurred at <u>6³⁰ P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>James W. Outkoff</u>			M.D. <u>Takoma Park, Md</u>		DATE SIGNED <u>1-13-56</u>		
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial Jan 15-1956</u>				<u>Farmington Cemetery</u>		<u>Jackson Ohio</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Jan. 13-1956</u>		<u>J. H. Harris</u>		<u>S.H. Harris Co</u>		<u>2901-14 St. M. W. Wash. D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 17 1936

RECEIVED

863

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH.

COUNTY Montgomery MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town) Silver Spring Md
 OR and give nearest town) 2 yrs
 TOWN in this place
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 9823 - Wendell St. Ave

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE D. C. COUNTY Washington
 CITY (If outside corporate limits, write RURAL and give nearest town) Washington
 OR TOWN 1124 Kalania St. N.W.
 STREET ADDRESS (If rural give location)

3. NAME OF DECEASED:

(Type or Print) William Watson Stines
 (First) (Middle) (Last)

4. DATE (Month) (Day) (Year)
 OF DEATH: Jan 27 1956

5. SEX:

M

6. COLOR OR RACE:

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

Married

8. DATE OF BIRTH:

Oct 4 - 1865

9. AGE last birthday:

90 yrs

10. IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

Hotel

11. BIRTHPLACE (State or foreign country):

Bidford, Penna

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME:

David Stines

14. MOTHER'S MAIDEN NAME:

Mary Shortzger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): If Yes, give war or dates of service:

No

16. SOCIAL SECURITY NO.

577-3-0355AX

17. INFORMANT & ADDRESS:

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE

(A)

Acute Cardiac Failure

INTERVAL BETWEEN ONSET AND DEATH

2 weeks

ANTECEDENT CAUSE (S):

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST

(B)

Arteriosclerotic Heart Disease25 years

DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.

21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

M.

21E. INJURY OCCURRED While ☐ Not while ☐ at work at work

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1, 1947 to Jan 27, 1956 that I last saw the deceased

alive on 1/27/56, 19 56, and that death occurred at 8:10 P.M. from the causes and on the date stated above.

SIGNATURE

John E. Everett

M.D.

ADDRESS

1301-14th St. Wash, DC

DATE SIGNED

1/27/56

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

DATE THEREOF

1-30-56

NAME OF CEMETERY OR CREMATORY

Union Cem.

LOCATION (City, town, or county)

Meyersdale, Pa.

(State)

DATE REC'D BY LOCAL REGISTRAR

1-31-56

REGISTRAR'S SIGNATURE

Frances Teller

24. FUNERAL DIRECTOR

H.P. Kondow, Meyersdale, Pa.

ADDRESS

MARGIN RESERVED FOR BINDING

BUREAU OF



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

870				00848	
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18				Reg. Dist.	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				No. 216	
1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>D.C.</u> COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Washington, D.C.</u>	
X TOWN <u>Rural-Bethesda</u>				STREET ADDRESS (If rural, give location) <u>2300 Conn. Ave., N.W.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS					
3. NAME OF DECEASED: (First) (Middle) (Last)			4. DATE OF DEATH (Month) (Day) (Year)		
<u>CAROLYN VanDOLAH TALLEY</u>			<u>Jan 4th 19 56</u>		
5. SEX:	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday: yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>Sep. 3, 1914</u>	<u>41</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>		11. BIRTHPLACE (State or foreign country): <u>Ill.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME: <u>Louis S. VanDolah</u>		14. MOTHER'S MAIDEN NAME: <u>Blanch Stool</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No.: <u>yes</u>		17. INFORMANT & ADDRESS: <u>Grant S. Talley- Item 2</u>	
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a)..... <u>Acute Barbitol Poisoning</u>					<u>?</u>
DUE TO					
Antecedent cause(s) (b)..... <u>ingestion of Sodium Seconal</u>					<u>?</u>
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)					
DUE TO					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:			20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>John S. Ball</u>		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>4 Jan 56</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Cremation</u>		DATE THEREOF <u>1-6-56</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	
LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>		24. FUNERAL DIRECTOR <u>Robert S. Campbell</u>		ADDRESS <u>Bethesda, Md.</u>	
DATE REC'D BY LOCAL REG. <u>1/9/56</u>		REGISTRAR'S SIGNATURE <u>Deirdre M. Thompson</u>			

THE UNIVERSITY OF CHICAGO

LIBRARY

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00849

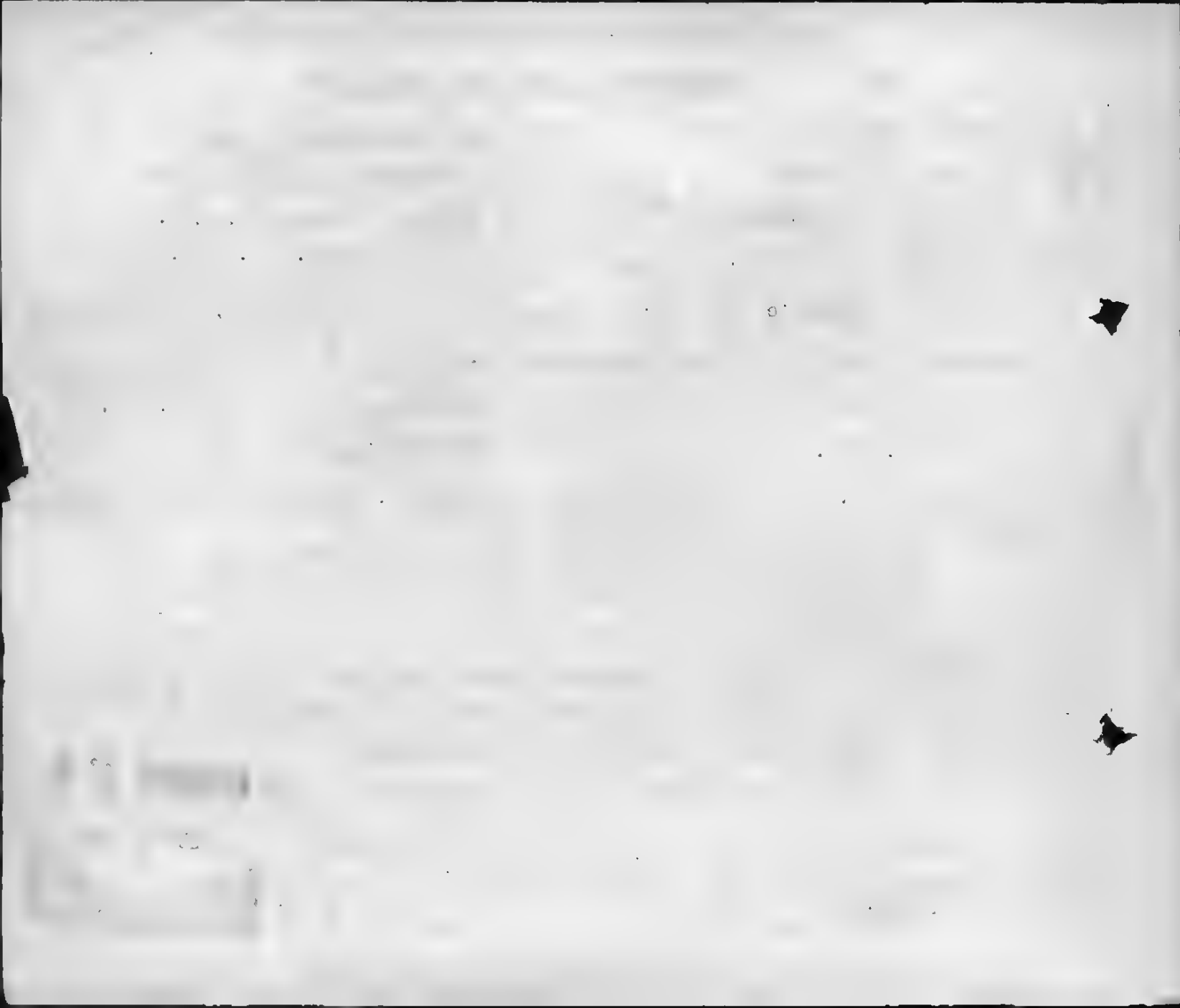
871

CERTIFICATE OF DEATH

Reg. Dist. No. 216

Item 1. Film GL92 2-6-56 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Montgomery</u>		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Glen Manor Park</u>				TOWN <u>Rural Washington, D. C.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5712 Mass. Avenue</u>				STREET ADDRESS <u>5712 Mass. Ave. N. W.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Charlotte</u> (Middle) <u>Carr</u> (Last) <u>Taylor</u>				(Month) <u>Jan.</u> (Day) <u>26</u> (Year) <u>19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>April 21, 1881</u>	<u>74</u> yrs.	Months <u>10</u>	Days <u>5</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>None</u>		<u>None</u>		<u>Maryland</u>		<u>U.S. A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Edward T. Carr.</u>				<u>Emma Bollinger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Mavis T. Overstreet</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
332X IMMEDIATE CAUSE (A) <u>CEREBRAL THROMBOSIS</u>						<u>4 DAYS</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>CORONARY</u>						<u>6 1/2 YEARS</u>	
(C) <u>CEREBRAL</u>						<u>6 1/2 YEARS</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>OCT</u> , 19 <u>55</u> , to <u>1/26</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/26</u> , 19 <u>56</u> , and that death occurred at <u>2:40 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>N. T. Overstreet</u>				ADDRESS (Street, city, town, state) <u>11-1016-16 5th N.W. D.C.</u>		DATE SIGNED <u>1/26/56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Removal</u>		<u>1/28/56</u>		<u>ROANOKE, VA.</u>			
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>1-30-56</u>		<u>Bessie M. Horn</u>		<u>Martin W. Hyson & Co.</u>		<u>1300 N. St. N.W.</u>	



872

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	OR TOWN
<u>Bethesda</u>	<u>16 days</u>	<u>Bethesda</u>	<u>Bethesda</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>Suburban Hospital</u>		<u>4705 Highland Ave.</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>William</u>	(Middle) <u>Dudley</u>	(Last) <u>Terry</u>	(Month) <u>Jan</u>
(Type or Print)			(Day) <u>25</u>
			(Year) <u>1956</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 6, 1889</u>
			9. AGE last birthday <u>68</u> yrs.
			IF UNDER 1 YEAR Months <u>5</u> Days <u>19</u> Hours <u></u> Min. <u></u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
<u>Instrument Maker</u>		<u>Mohawk New York</u>	
11. FATHER'S NAME:		12. CITIZEN OF WHAT COUNTRY?	
<u>Jerome Terry</u>		<u>U.S.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Jerome Terry</u>		<u>Roudine, Jenny</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>WW I</u>		<u>214-18-8028</u>	
17. INFORMANT & ADDRESS:		18. MEDICAL CERTIFICATION	
<u>Wife, Mildred Terry - above</u>		I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
		IMMEDIATE CAUSE (A) <u>Pneumonia, bronchitis</u>	
		DUE TO	
		ANTECEDENT CAUSE (B) <u>chronic emphysema</u>	
		DUE TO	
		DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	
		(C) <u>Coronary Arteriosclerosis</u>	
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		<u>Carcinoma Rectum</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<u>2</u>			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan 4</u> , 19 <u>56</u> , to <u>Jan 25</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 4</u> , 19 <u>56</u> , and that death occurred at <u>3:20 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Dr. O. O. Thompson</u>		DATE SIGNED <u>1/25/56</u>	
ADDRESS <u>M. D. 8016 Highland Ave.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<u>Burial</u>		<u>1-27-1956</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Arlington National</u>		<u>Arlington Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR ADDRESS	
<u>1-31-56</u>		<u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WHITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



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CERTIFICATE OF DEATH

Reg. Dist. No. 216....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u> MARYLAND		STATE <u>MD</u> COUNTY <u>Mont.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cherry Chase</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cherry Chase</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6716 Fairfax Rd</u>		STREET ADDRESS (If rural give location) <u>6716 Fairfax Rd.</u>		3. NAME OF DECEASED: (First) <u>Olin</u> (Middle) <u>B.</u> (Last) <u>Tharp</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan. 26</u> 19 <u>56</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE. MARRIED. WIDOWED, DIVORCED. <u>married</u>	8. DATE OF BIRTH: <u>4-19-1896</u>	9. AGE last birthday <u>59</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired): <u>Western Elec. Co. Telephone Equipment</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>West Va</u>		11. BIRTHPLACE (State or foreign country): <u>U. S.</u>	
13. FATHER'S NAME: <u>John L Tharp</u>				14. MOTHER'S MAIDEN NAME: <u>Bosley</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY No. <u>577-09-9820</u>		17. INFORMANT & ADDRESS: <u>Mrs G. Tharp 6716 Fairfax Rd. Ch. Ch. Md</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>PULMONARY INFARCTION</u>						<u>5 minutes</u>	
ANTECEDENT CAUSE (B) <u>MYOCARDIAL INFARCTION</u>						<u>1 year</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>HYPERTENSION</u>						<u>6 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 24</u> , 19 <u>56</u> , to <u>Jan 26</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 24</u> , 19 <u>56</u> , and that death occurred at <u>9 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Walter B. Credit</u>		ADDRESS <u>M. D. Washington Clinic</u>		DATE SIGNED <u>1/26/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-30-56</u>		NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cem</u>		LOCATION (City, town, or county) (State) <u>P. Geo. County</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-26-56</u>		REGISTRAR'S SIGNATURE <u>Bernie M. Thompson</u>		24. FUNERAL DIRECTOR ADDRESS <u>St. Hones Co 2901-14th St. N.W. Wash. D.C.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

THE OVERSEA

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CERTIFICATE OF DEATH

Reg. Dist. No. 223...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Montgomery</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Montgomery</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Takoma Park</i>		LENGTH OF STAY (in this place) <i>39 days</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Cherry Chase</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Washington Sanitarium Hospital</i>				STREET ADDRESS (If rural give location) <i>3509 Woodlawn St</i>			
3. NAME OF DECEASED: (First) <i>Lebbie</i> (Middle) <i>W.</i> (Last) <i>Tolson</i>				4. DATE (Month) (Day) (Year) OF DEATH: <i>1 - 1 - 1956</i>			
5. SEX: <i>Female</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>married</i>	8. DATE OF BIRTH: <i>12-23-1900</i>	9. AGE last birthday <i>55</i> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Housewife</i>				10B. KIND OF BUSINESS OR INDUSTRY: <i>—</i>		11. BIRTHPLACE (State or foreign country): <i>Penna</i>	
13. FATHER'S NAME: <i>Bernard Matthews</i>				14. MOTHER'S MAIDEN NAME: <i>Rose Kessiloff</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>no</i>				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <i>Washington Sanitarium Hospital Records</i>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <i>Recurrent adenocarcinoma sigmoid</i>		<i>18 mo.</i>
ANTECEDENT CAUSE (S) DUE TO <i>with metastasis</i>		
(B) <i>adenocarcinoma ascending colon</i>		<i>5 1/2 yrs</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
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19A. DATE OF OPERATION: <i>3.9.55</i>	19B. MAJOR FINDINGS OF OPERATION: <i>Recurrent malignancy involving pelvic fascia in sigmoid region secondary to adenocarcinoma colon & ovaries</i>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from *May*, 1950, to *1-1-1956*, that I last saw the deceased alive on *12-31*, 1955, and that death occurred at *...* M, from the causes and on the date stated above.

SIGNATURE <i>Stanley Paul Brown</i>		ADDRESS <i>M.D. 300 Hamilton St. N.W.</i>		DATE SIGNED <i>1-1-56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	DATE THEREOF <i>Jan 3-1956</i>	NAME OF CEMETERY OR CREMATORY <i>Brais Israel Cem</i>	LOCATION (City, town, or county) <i>Oxon Hill</i>	(State) <i>MD</i>	
DATE REC'D BY LOCAL REGISTRAR <i>Jan 1-1956</i>	REGISTRAR'S SIGNATURE <i>J. Wilson Nodd</i>	24. FUNERAL DIRECTOR <i>B. Dargatzis & Son</i>	ADDRESS <i>Wash. D.C.</i>		

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

874

CERTIFICATE OF DEATH

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Reg. Dist. No. 214

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY MONTGOMERY		MARYLAND		STATE MARYLAND		COUNTY MONTGOMERY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN SILVER SPRING		LENGTH OF STAY (in this place) 34 yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN SILVER SPRING			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 638 RITCHIE AVENUE				STREET ADDRESS (If rural give location) 638 RITCHIE AVENUE			
3. NAME OF DECEASED (First) (Middle) (Last) (Type or Print) JOHN A. VAN HORN				4. DATE OF DEATH (Month) (Day) (Year) JAN. 16 1956			
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH FEB. 28, 1866	9. AGE last birthday 89 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLASTERER - RETIRED			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME OLIVER VAN HORN				14. MOTHER'S MAIDEN NAME SALLY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-05-4088		17. INFORMANT & ADDRESS Mr. Herbert Van Horn 4624 Saul Rd., Kensington, Maryland			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Cerebral arteriosclerosis							
ANTECEDENT CAUSE(S) DUE TO (B) Generalized arteriosclerosis							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Arteriosclerotic heart disease							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 14, 1953, to Jan 16, 1956, that I last saw the deceased alive on Jan 12, 1956, and that death occurred at 12:55 PM, from the causes and on the date stated above.							
SIGNATURE Adrian H. Trautman				ADDRESS (Street, city, town, state) 5237 Georgia Ave Silver Spring Md 416-8		DATE SIGNED 1/16-56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 1/19/56		NAME OF CEMETERY OR CREMATORY GEO. WASH. MEM. CEMETERY		LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MARYLAND	
24. REC'D BY REGISTRAR DATE 1-19-56		REGISTRAR'S SIGNATURE Francis Tetter		25. FUNERAL DIRECTOR'S SIGNATURE Werner E. Humphrey		ADDRESS SILVER SPRING, MD.	

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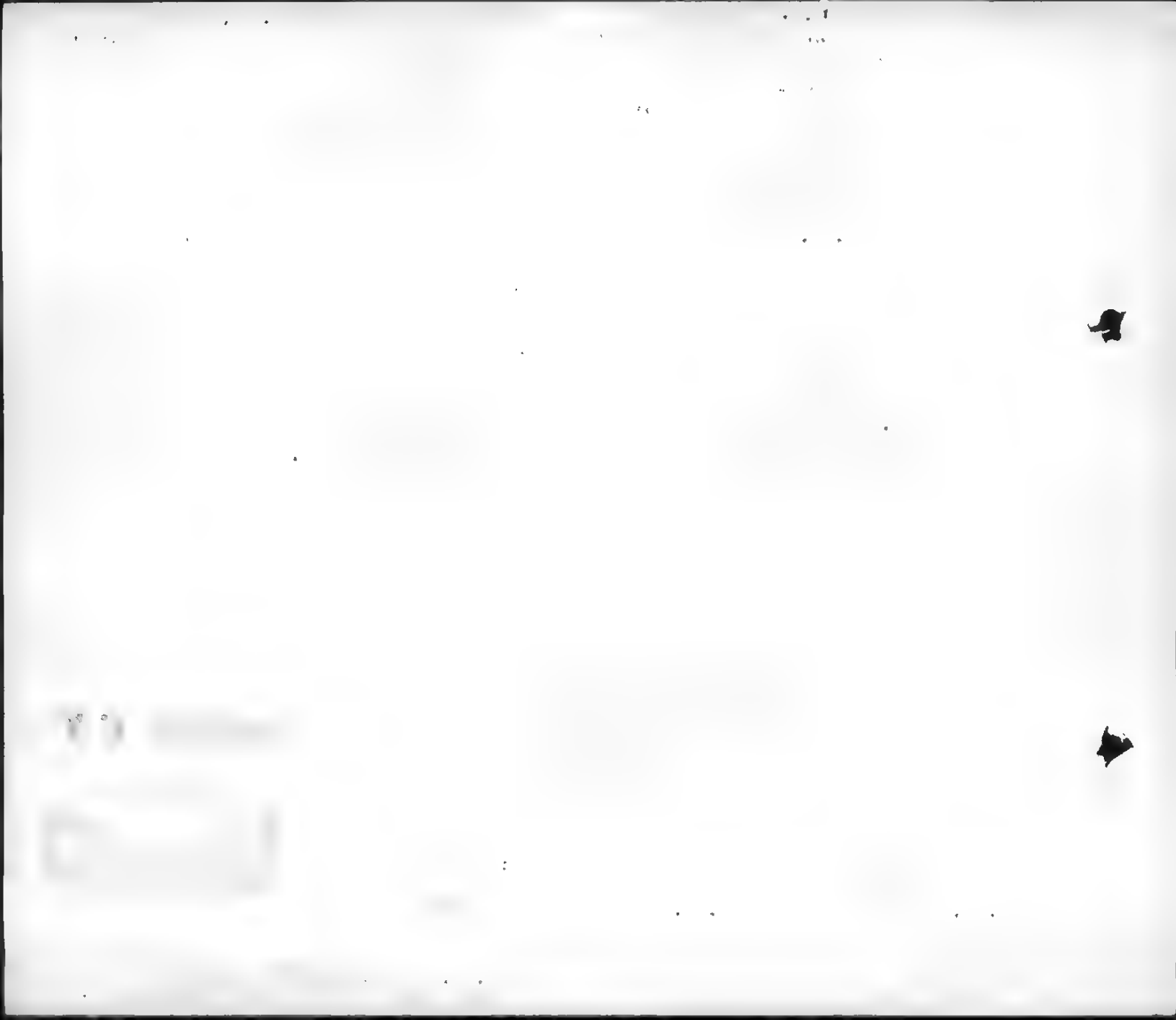
CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Montgomery		MARYLAND		STATE Maryland		COUNTY Montgomery	
CITY (If outside corporate limits, write RURAL and give nearest town) OR Bethesda Rural		LENGTH OF STAY (in this place) 10 days		CITY (If outside corporate limits, write RURAL and give nearest town) OR Rockville			
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital 1				STREET ADDRESS (If rural give location) 1214 Crawford Street			
3. NAME OF DECEASED: (First) Jack (Middle) Lee (Last) VAN SCYOC				4. DATE (Month) (Day) (Year) OF DEATH: January 11 19 56			
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single	8. DATE OF BIRTH: 1-1-56	9. AGE last birthday yrs. 10	IF UNDER 1 YEAR: Months 10 Days 10 Hours 10 Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None		10B. KIND OF BUSINESS OR INDUSTRY: None		11. BIRTHPLACE (State or foreign country): Bethesda, Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME: Charles D. VAN SCYOC				14. MOTHER'S MAIDEN NAME: Edna LAYTON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No		16. SOCIAL SECURITY No. None		17. INFORMANT & ADDRESS: Father Charles D. VAN SCYOC Same as above			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Cardiac arrest (surgery)							
ANTECEDENT CAUSE (B) 12 hrs							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. INTESTINAL OBSTRUCTION							
19A. DATE OF OPERATION: 11 Jan '56		19B. MAJOR FINDINGS OF OPERATION: INTESTINAL OBSTRUCTION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1 Jan, 1956 , to 11 Jan, 19 56 that I last saw the deceased alive on 11 Jan, 1956 , and that death occurred at 3:13 AM , from the causes and on the date stated above.							
SIGNATURE H. A. PEARSON				ADDRESS MC USN U. S. Naval Hospital, NNMC, Bethesda, Maryland		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 17 Jan 1956		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State) Illinois	
DATE REC'D BY LOCAL REGISTRAR 11 Jan 1956		REGISTRAR'S SIGNATURE Mary E. Parrell		R. A. Funeral Home ADDRESS 7557 Wisconsin Avenue, Bethesda, Md.			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH

Reg. Dist. No. 223

735

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Wash., D.C.</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
OR TOWN <u>Takoma Park</u>	<u>1-16-56 to</u>	OR TOWN <u>Washington, D.C.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>Washington Sanitarium or Hospital</u>	<u>1-18-56</u>	<u>1717 E. Capitol Street</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>John</u>	(Middle) <u>Nicholis</u>	(Last) <u>Vasiliadis</u>	(Date) <u>January 18, 1956</u>
(Type or Print)			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>10-18-1893</u>
			9. AGE last birthday <u>62</u> yrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Salesman</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Crusty Pie Co.</u>	
11. BIRTHPLACE (State or foreign country): <u>Constantinople</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME: <u>Nicholas Vasiliadis</u>		14. MOTHER'S MAIDEN NAME: <u>Asposia Agapiou</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>(If Yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Mrs. Beulah M. Vasiliadis</u>		<u>1717 E. Capitol St., Wash., D.C.</u>	
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Cornary Thrombosis</u>		<u>Sudden</u>	
ANTECEDENT CAUSE (B) <u>Bilat. Pneumonia</u>		<u>3 days</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C) <u>Cornary Thrombosis</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		<u>Feb 28 1951</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street-office bldg., etc.)	
		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While at work Not while at work	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>6/4</u> , 19 <u>56</u> , to <u>1/18</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/18</u> , 19 <u>56</u> , and that death occurred at <u>10:23</u> M, from the causes and on the date stated above.			
SIGNATURE <u>J. I. House</u>		DATE SIGNED <u>1/18/56</u>	
M. D. <u>2030</u>		<u>Carroll's Tobacco Shop</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>St. Lincoln Cem</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Jan 19-1956</u>		REGISTRAR'S SIGNATURE <u>J. I. House</u>	
24. FUNERAL DIRECTOR		ADDRESS	
<u>St. Louis Co. 2901-14</u>		<u>22 NW 42</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

U. S. DEPARTMENT OF AGRICULTURE

1914

876

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Montgomery</i>	MARYLAND	STATE <i>Md.</i>	COUNTY <i>Montgomery</i>
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	LENGTH OF STAY (in this place) <i>5 yrs</i>	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>921 Philadelphia Avenue</i>		STREET ADDRESS (If rural give location) <i>921 Philadelphia Avenue</i>	
3. NAME OF DECEASED: (Type or Print) <i>LELIA</i> (First) <i>WEBB</i> (Last)		4. DATE (Month) (Day) (Year) OF DEATH: <i>Jan. 29 1956</i>	
5. SEX: <i>Female</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>	8. DATE OF BIRTH: <i>Dec. 31, 1876</i>
9. AGE last birthday: <i>79</i> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>at home</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>Homemaker</i>	
11. BIRTHPLACE (State or foreign country): <i>Knox County, Illinois</i>		12. CITIZEN OF WHAT COUNTRY: <i>U.S.A.</i>	
13. FATHER'S NAME: <i>Andrew Lowman</i>		14. MOTHER'S MAIDEN NAME: <i>Francis Agnew</i>	
15. WAS DECEASED EVER IN U.S. ARMY OR NAVY (Yes, no, or unk.): <i>no</i> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <i>Litcher P. Webb, 921 Philadelphia Ave S Md</i>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
442X IMMEDIATE CAUSE		Atherosclerosis	
ANTECEDENT CAUSE (S)		(A) <i>Hypertension & renal insufficiency</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) <i>Coronary atherosclerosis</i>	
		(C) <i>Coronary atherosclerosis & auralicular fibrillation</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		<i>Thyroidosis? not contributory</i>	
19A. DATE OF OPERATION: <i>0</i>		19B. MAJOR FINDINGS OF OPERATION: <i>0</i>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: <i>0</i> M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>1950</i> 19 <i>to 1/29/56</i> , that I last saw the deceased alive on <i>1/27/56</i> 19 <i>56</i> , and that death occurred at <i>9:50 P</i> M, from the causes and on the date stated above.			
SIGNATURE <i>Dr. H. S. Johnson</i>		ADDRESS <i>500 Underwood Lane NW</i> DATE SIGNED <i>1/29/56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Transit-Burial</i>		DATE THEREOF <i>Feb 1, 1956</i>	
NAME OF CEMETERY OR CREMATORY <i>Lynnhurst Cemetery</i>		LOCATION (City, town, or county) (State) <i>Knoxville, Tennessee</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <i>Frances Toller</i>	
24. FUNERAL DIRECTOR <i>J. Arthur Walters</i>		ADDRESS <i>254 Carroll St NW, Wc</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

BUREAU A. S.

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

877

CERTIFICATE OF DEATH

Reg. Dist. No. 215

00857

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
X TOWN <u>Bethesda Rural</u>		<u>5 days</u>		TOWN <u>Cheverly</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S. Naval Hospital</u>				STREET ADDRESS (If rural give location) <u>6001 Euclid Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
(Type or Print) <u>Glenn</u> <u>Raymond</u> <u>WEGER</u>				DEATH: <u>Jan</u> <u>23</u> <u>1956</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>7 Jul 50</u>	<u>5 yr 6mo yrs.</u>	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
-----		-----		<u>Maryland</u>		<u>US</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Raymond A. WEGER</u>				<u>Glare PENN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
(If Yes, give war or dates of service)		-----		<u>Raymond A. Weger, Same as #2</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
19.3 x IMMEDIATE CAUSE (A) <u>medulloblastoma</u>						30 mos.	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						2 mos.	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
<u>12/14/53</u>		<u>medulloblastoma</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>18 Jan., 1956</u> , to <u>23 Jan., 1956</u> , that I last saw the deceased <u>23 Jan., 1956</u> , and that death occurred at <u>12:20 P.M.</u> , from the causes and on the date stated above.							
<u>R.W. Mackie</u>				ADDRESS DATE SIGNED			
<u>R.W. MACKIE, CDR MC USN</u>				<u>M.D. U.S. NAVAL HOSPITAL BETHESDA MD</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>26 Jan 1956</u>		<u>Arlington National</u>		<u>Arlington Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		Washington, D.C.	
<u>23 Jan 1956</u>		<u>Mary E. Russell</u>		<u>LEE FUNERAL HOME 4th & Massachusetts,</u>			

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Reg. Dist. No. 214

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1020 Quebec Terrace</u>		STREET ADDRESS (If rural give location) <u>1020 Quebec Terrace</u>	
3. NAME OF DECEASED: (First) <u>Ruegel</u> (Middle) <u>Culp</u> (Last) <u>Weitzel</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>1</u> <u>25</u> <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>M</u>	8. DATE OF BIRTH: <u>Oct. 9, 1897</u>
9. AGE last birthday <u>58</u> yrs		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS: Hours <u> </u> Min. <u> </u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Plumbing Inspector</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Shamokin, Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Daniel Wm. Weitzel</u>		14. MOTHER'S MAIDEN NAME: <u>Lettie May Culp</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>202-09-3916</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Nellie T. Weitzel, 1020 Quebec Terrace Silver Spring, Maryland</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE		(A) <u>Heart coronary thrombosis</u>	
ANTECEDENT CAUSE (S):		DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) <u>Coronary insufficiency</u>	
		DUE TO	
		(C) <u>Arteriosclerotic cardiovascular disease</u>	
		DUE TO	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) OF INJURY		21F. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>1-25</u> , 1956, to <u>1-25</u> , 1956, that I last saw the deceased alive on <u>1-25</u> , 1956, and that death occurred at <u>5:55 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>R. H. B. B. B.</u>		ADDRESS <u>M. D. 2513 Buck Lodge Rd. H. H. B. B. B.</u>	
DATE SIGNED <u>1/28/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/28/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		LOCATION (City, town, or county) (State) <u>Prince George County, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/27/56</u>		REGISTRAR'S SIGNATURE <u>Frances Foster Warner & Humphrey</u>	
24. FUNERAL DIRECTOR <u>Silver Spring, Md.</u>			

MARGIN RESERVED FOR BINDING

VS. A15-10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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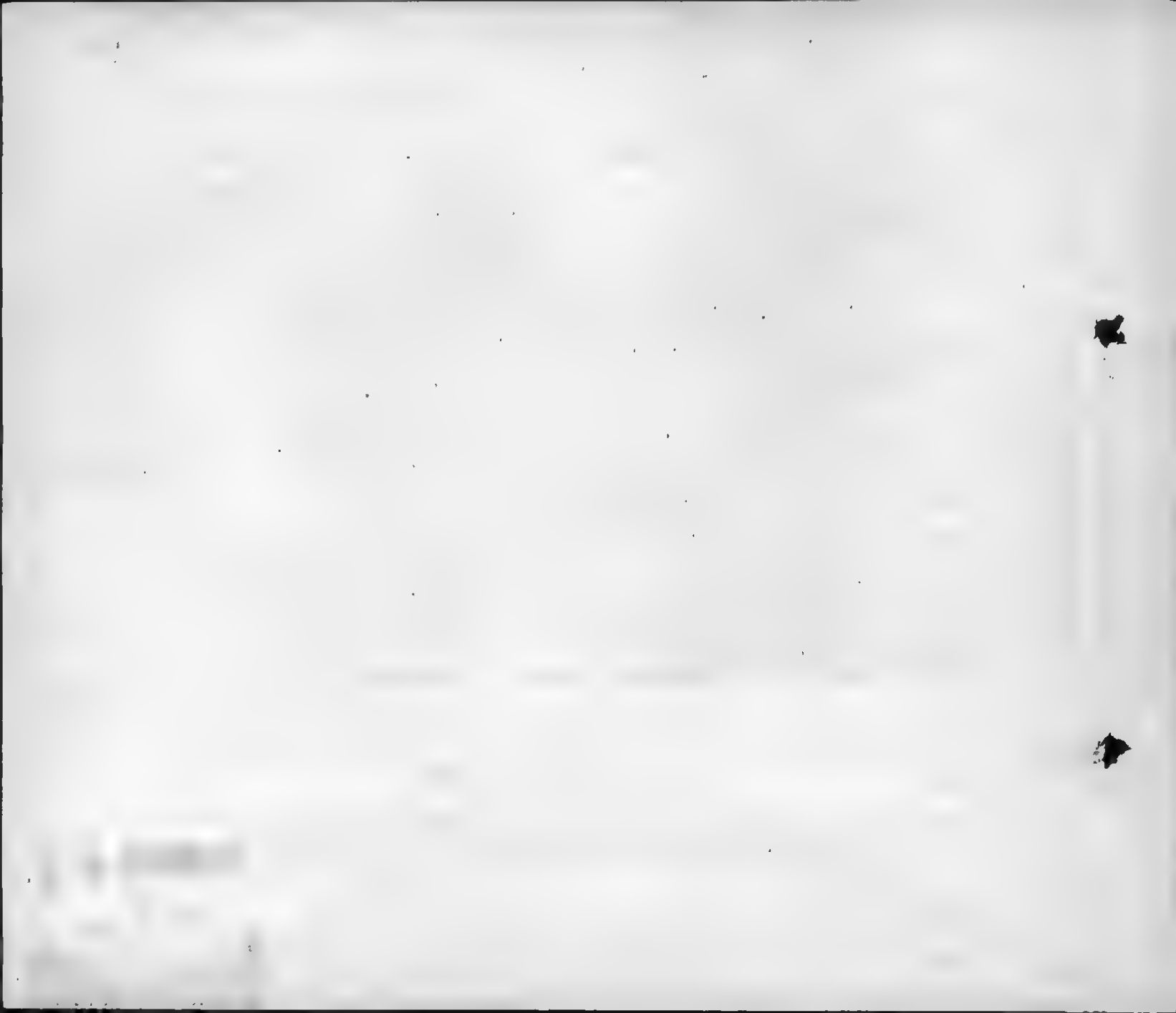
Item 9, Film 192 2-7-56 et

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<u>Bethesda</u>		<u>10 days</u>		<u>Cherry Chase</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
<u>Suburban</u>				<u>4700 Bradley Blvd.</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year) OF DEATH			
<u>Adelaide Reardon Wells</u>				<u>Jan. 25 1956</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>Widow</u>	<u>Feb. 9, 1888</u>	<u>66</u> yrs.	<u>11</u> Months	<u>16</u> Days	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY:		11 BIRTHPLACE (State or foreign country):	
<u>Housewife</u>						<u>Baltimore, Maryland</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>George Reardon</u>				<u>Emilie Fant</u>			
15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>No</u>				<u>None</u>		<u>Apt. 4c-208 East 70th St. Mary P. Bruns- New York City, New York</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A)							
<u>471x Respiratory Failure</u>							<u>See above</u>
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B) <u>Compensated Bronchopneumonia</u>							<u>Five days</u>
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<u>Anesthesia & Surgical Shock</u>							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<u>24 Jan. '56</u>				<u>Carcinoma Spleen Flexure Colon</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While at work Not while at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan. 25</u> , 19 <u>56</u> to <u>Jan. 25</u> , 19 <u>56</u> that I last saw the deceased alive on <u>Jan 26</u> , 19 <u>56</u> , and that death occurred at <u>8:55 AM</u> , from the causes and on the date stated above.							
SIGNATURE				ADDRESS		DATE SIGNED	
<u>John W. Ball</u>				<u>M.D. 7936 Arlington Rd Bethesda Md</u>		<u>1/25/56</u>	
23. BURIAL CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1/27/1956</u>		<u>Arlington National</u>		<u>Arlington Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		FUNERAL DIRECTOR		ADDRESS	
<u>1-31-56</u>		<u>Beau M. Thompson</u>		<u>Robert A. Humphrey</u>		<u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING



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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **72 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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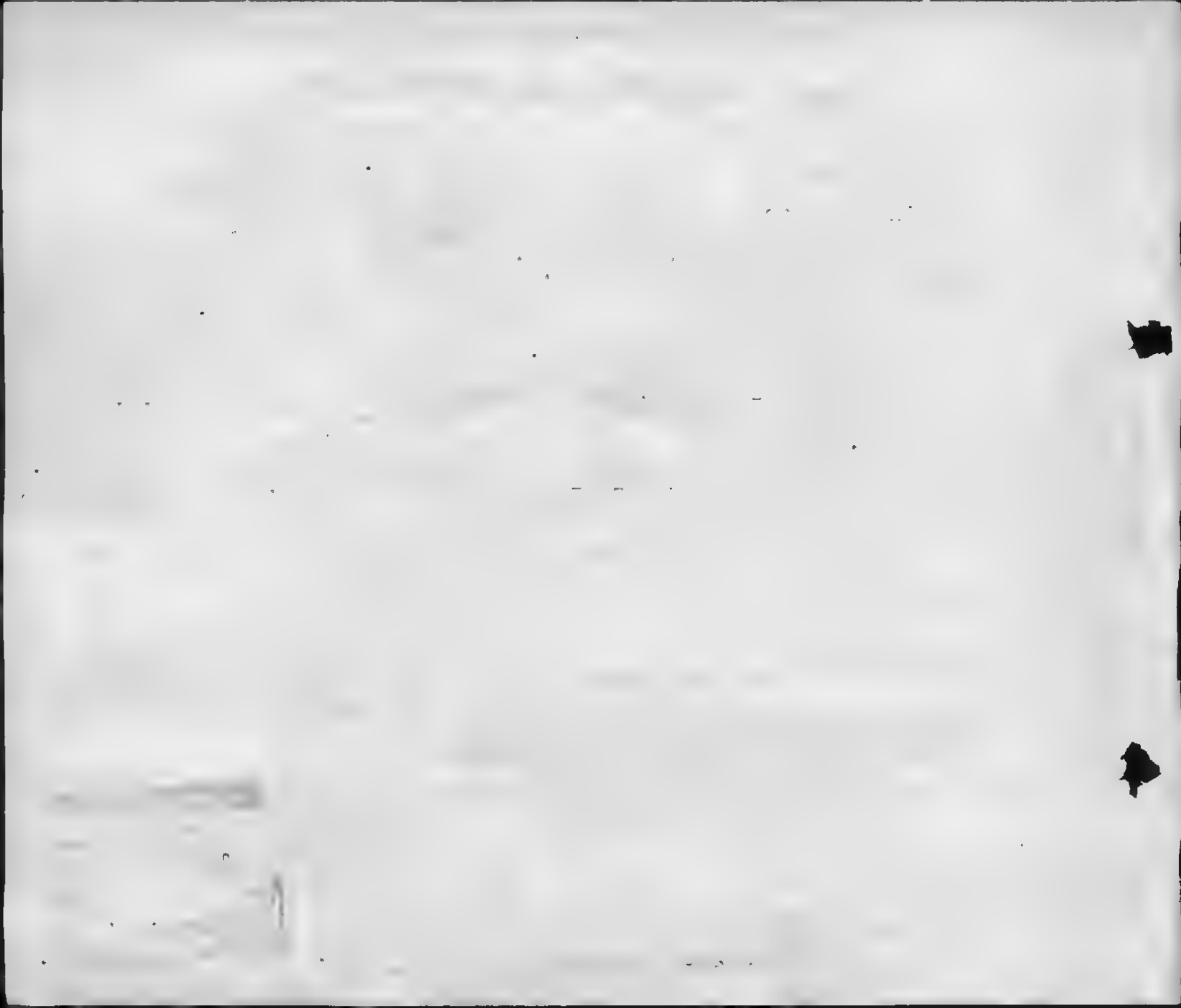
CERTIFICATE OF DEATH

00860

214

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Montgomery</u>		STATE <u>Md.</u>		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
TOWN				TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Greens Nursing Home</u> <u>Colesville Road, Silver Spg.</u>				STREET ADDRESS (If rural give location) <u>14428 Colesville Road</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Choulette</u> <u>S</u> <u>Wenner</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Jan.</u> <u>8</u> <u>19 56</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>single</u>		8. DATE OF BIRTH <u>Feb. 3, 1870</u>	
						9. AGE last birthday <u>85</u> yrs.	
						IF UNDER 1 YEAR Months Days Hours Min.	
						IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Buyer-</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Garfinckels</u>		11. BIRTHPLACE (State or foreign country) <u>Near Lovettsville, Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Jonathan A. Wenner</u>				14. MOTHER'S MAIDEN NAME <u>Mary Catherine Alder</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>577-20-0198</u>		17. INFORMANT & ADDRESS <u>14428 Colesville Rd.</u> <u>Miss Rachel M. Crown</u> <u>S.S.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						16. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>A p. p. l. y. i. n. , I. d. m. b. t. i. n.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic degenerative</u>						<u>3 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 2</u> , 19 <u>55</u> , to <u>Jan</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 2</u> , 19 <u>56</u> , and that death occurred at <u>12:25</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Ad. Bonquet</u>				ADDRESS (Street, city, town, state) <u>M.D. Sandy Spring, Md.</u>		DATE SIGNED <u>1/2/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>January 11, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
24. REC'D BY REGISTRAR <u>Francis Potter</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>2901 14th St. N. W. Washington, D.C.</u> <u>The S. H. ... Company</u>			
DATE <u>1-10-56</u>							



881

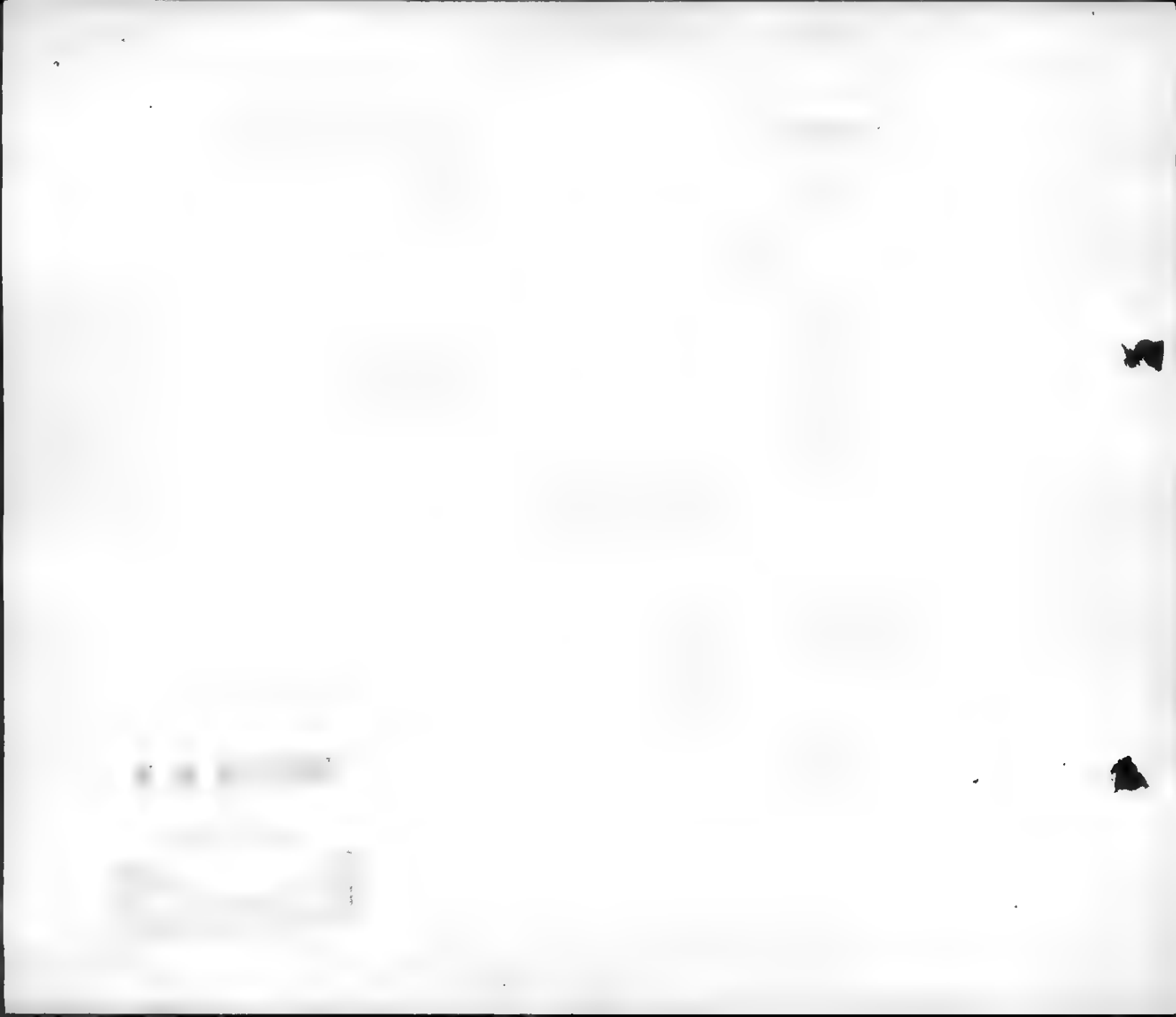
CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY MONTGOMERY	MARYLAND	STATE MARYLAND	COUNTY MONTGOMERY
CITY (If outside corporate limits, write RURAL OR and give nearest town) SILVER SPRING	LENGTH OF STAY (in this place) 46 years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN SILVER SPRING	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 8718 FIRST AVENUE		STREET ADDRESS (If rural give location) 8718 FIRST AVENUE	
3. NAME OF DECEASED: (First) (Middle) (Last) RACHEL COOKE WHITACRE		4. DATE (Month) (Day) (Year) OF DEATH: JANUARY 9 1956	
5. SEX: female	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed	8. DATE OF BIRTH: DEC. 27, 1879
9. AGE last birthday: 76 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOMEMAKER		10B. KIND OF BUSINESS OR INDUSTRY: OWN HOME	
11. BIRTHPLACE (State or foreign country): GAITHERSBURG, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME: NATHAN P. COOKE		14. MOTHER'S MAIDEN NAME: CATHERINE S. COOPER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY No. None	
17. INFORMANT & ADDRESS: Miss Pauline E. Whitacre, 8718 1st Ave., SS. Md.			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE 420.0			
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) Coronary Thrombosis			Sudden
DUE TO			
(B) Arteriosclerotic Heart Disease			
DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 6/16 , 19 50 to 1/9 , 19 56 , that I last saw the deceased alive on 1/9 , 19 56 , and that death occurred at 8 P.M. , from the causes and on the date stated above.			
SIGNATURE Maria Bausch		DATE SIGNED 1/9/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF JAN. 12, 1956	
NAME OF CEMETERY OR CREMATORY FOREST OAK CEMETERY		LOCATION (City, town, or county) (State) GAITHERSBURG, MARYLAND	
DATE REC'D BY LOCAL REGISTRAR 1-11-56		REGISTRAR'S SIGNATURE Frances Potter	
24. FUNERAL DIRECTOR Warner E. Pumphrey		ADDRESS SILVER SPRING, MD.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



882

00862
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 213

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Rockville</u>	LENGTH OF STAY (in this place) <u>3 yrs.</u>	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Rockville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rt. 1 South Glen Rd</u>		STREET ADDRESS (If rural, give location) <u>Rt. 1. South Glen Road</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>EDWARD</u>	(Middle) <u>B</u>	(Last) <u>WILBLR</u>	(Month) <u>Jan.</u> (Day) <u>2</u> (Year) <u>1956</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>9-24-1902</u>
9. AGE last birthday: <u>53</u> yrs.		10. IF UNDER 1 YEAR: <u>3</u> Months <u>8</u> Days	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Asst. Sec. State Dept.</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Government</u>	
11. BIRTHPLACE (State or foreign country): <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Thomas Cornelius Wilber</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Meade</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>None</u>	
17. INFORMANT & ADDRESS: <u>Son, Edward B. Wilber Jr. South Glen Rd Rockville</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
Immediate cause (a) <u>Cardiac Failure -</u>		<u>5 min.</u>
DUE TO		
Antecedent cause(s) (b) <u>Coronary occlusion -</u>		<u>5 min.</u>
DISEASES OR CONDITIONS, if any, giving rise to the above cause stating underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION: <u>0</u>		19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <u>John B. Bell</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>1/3/56</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>1-5-1956</u>	NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>
LOCATION (City, town, or county) (State) <u>Rockville Maryland</u>	24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>	ADDRESS <u>Bethesda, Md.</u>
DATE REC'D BY LOCAL REG. <u>1/6/56</u>	REGISTRAR'S SIGNATURE <u>Laurel H. Beagles</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

883

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00863

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH: SILVER SPRING 406 MANFIELD RD COUNTY MONTEGOMERY MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE SAME COUNTY Montg			
CITY (If outside corporate limits, write RURAL OR and give nearest town) SILVER SPRING TOWN				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN SILVER SPRING			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) 406 MANFIELD Rd. Silver Spring			
3. NAME OF DECEASED: (First) MARIAN (Middle) G. (Last) WISEMAN				4. DATE (Month) (Day) (Year) OF DEATH: JAN. 6 1956			
5. SEX: FEMALE		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED		8. DATE OF BIRTH: JULY 28, 1916	
9. AGE last birthday: 37 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE		11. BIRTHPLACE (State or foreign country): WASHINGTON D.C.		12. CITIZEN OF WHAT COUNTRY: U.S.A.	
13. FATHER'S NAME: SAMUEL ZUKERMAN				14. MOTHER'S M maiden NAME: LENA LEANER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. —			
17. INFORMANT & ADDRESS: LEON WISEMAN - 406 MANFIELD RD SILVER SPRING MD				18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (A) Carcinoma of breast with metastases				Ovary			
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.			
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?							
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from Dec 23, 1953 to Jan 6, 1956 , that I last saw the deceased alive on Jan 1, 1956 , and that death occurred at 4:35 P.M. from the causes and on the date stated above.							
SIGNATURE B. H. H. H.				DATE SIGNED JAN 6, 1956			
ADDRESS M. D. 8641 Columbia Rd Silver Spring Md							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				DATE REC'D BY LOCAL REGISTRAR Dec 8/1956			
REGISTRAR'S SIGNATURE Frances J. Teller				24. FUNERAL DIRECTOR B. H. H. H.			
ADDRESS 1-10-56							

U.S. AIR FORCE

884

CERTIFICATE OF DEATH

Reg. Dist. No. 24 4

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Montg</i>	MARYLAND	STATE <i> Md. </i>	COUNTY <i> Montg </i>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place) <i> 1 year </i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i> Bel Air Springs </i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location) <i> 7020-Fairview Rd. </i>	
3. NAME OF DECEASED: (Type or Print) <i> Mary </i> (First) <i> Boykin </i> (Middle) <i> Wolfe </i> (Last)		4. DATE (Month) (Day) (Year) OF DEATH: <i> 1 </i> <i> 26 </i> <i> 1956 </i>	
5. SEX <i> F </i>	6. COLOR OR RACE <i> W </i>	7. SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> (Specify):	8. DATE OF BIRTH: <i> JAN 10, 1868 </i>
9. AGE last birthday <i> 88 </i> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i> Housewife </i>		10B. KIND OF BUSINESS OR INDUSTRY: <i> - </i>	
11. BIRTHPLACE (State or foreign country): <i> Cleator, N.C. </i>		12. CITIZEN OF WHAT COUNTRY: <i> U.S.A. </i>	
13. FATHER'S NAME: <i> Robinson Fennell Boykin </i>		14. MOTHER'S MAIDEN NAME: <i> Ann Hobbs </i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <i> John F Wolfe - 7020-Fairview Rd. </i>			

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE	(A) Congestive left heart failure	10 days
ANTECEDENT CAUSE (B)	(B) Hypertensive heart disease	10 yrs
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(C) Atherosclerosis	4
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 3, 1956, to Jan 21, 1956, that I last saw the deceased alive on Jan 26, 1956, and that death occurred at 1130 P.M., from the causes and on the date stated above.

SIGNATURE	ADDRESS	DATE SIGNED
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23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
		1/30/56	Clinton Cem.	Clinton, N.C.	
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR		ADDRESS	
1-27-56	Frances Jetter	The S. H. Rimes Co.		2905 1st St. D.C.	

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3 3 100000

NY

100000

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00865

Reg. Dist.

No. 213

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Rockville</u>		LENGTH OF STAY (in this place) <u>6 mo</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Rockville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>818 Crothers Lane</u>				STREET ADDRESS (If rural, give location) <u>818 Crothers Lane</u>			
3. NAME OF DECEASED: (Type or Print) <u>Frederick James Woolfitt</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 23 1956</u>			
5. SEX: <u>male</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married Oct 20 1920</u>		8. DATE OF BIRTH: <u>35 yrs. 3 Months 3 Days</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>ant accountant</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>P.O. Dept.</u>		11. BIRTHPLACE (State or foreign country): <u>Mich</u>	
13. FATHER'S NAME: <u>Emerson Geo Woolfitt</u>				14. MOTHER'S MAIDEN NAME: <u>Ethel M Backstrom</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service) <u>YES N W II</u>				16. SOCIAL SECURITY No.: <u></u>		17. INFORMANT & ADDRESS: <u>Jane Woolfitt (wife) same as dec'd</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a)..... <u>Coronary occlusion</u>						1 hr.	
DUE TO							
Antecedent cause(s) (b).....							
Diseases or conditions, if any, giving rise to the above cause, stating underlying cause last (c)							
DUE TO							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Samuel B. Brochman</u>		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 1-23-56	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>1-20-1956</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem.</u>		LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
DATE REC'D BY LOCAL REG. <u>1/25/56</u>		REGISTRAR'S SIGNATURE <u>Lamell H. Bradley</u>		24. FUNERAL DIRECTOR <u>Robert W. Humphrey</u>		ADDRESS <u>Bethesda, Md.</u>	

8/2 1954

885

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>D.C.</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	LENGTH OF STAY (in this place) <u>4 3/4 hrs</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Washington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>		STREET ADDRESS (If rural give location) <u>824 Upshoe ST. N.W. ✓</u>	
3. NAME OF DECEASED: (First) <u>Elsie</u> (Middle) <u>J.</u> (Last) <u>Yarboro</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>1-18-1956</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widow</u>	8. DATE OF BIRTH: <u>12/30/00</u>
9. AGE last birthday: <u>55</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John Carland</u>		14. MOTHER'S MAIDEN NAME: <u>Mary A. Edwards Ward - Son-in-law 3102 Blueford Rd Kensington Md.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Edward Ward - Son-in-law 3102 Blueford Rd Kensington Md.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Cholera due to Liver Metastasis from (3 days)</u>			
ANTECEDENT CAUSE (S) (B) <u>Carcinoma of Breast (Rt.)</u>		6 months	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct. 10, 1955</u> , to <u>Jan. 18, 1956</u> that I last saw the deceased alive on <u>Jan. 18, 1956</u> and that death occurred at <u>2:16 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Samuel Allen</u>		DATE SIGNED <u>Jan. 18, 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan 21, 1956</u>	
NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		LOCATION (City, town, or county) (State) <u>Colmar Manor Md.</u>	
24. FUNERAL DIRECTOR <u>F. Gasch's Sons Hyattsville, Maryland.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 25 1951

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	LENGTH OF STAY (in this place) <u>3 hours</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban</u>		STREET ADDRESS (If rural give location) <u>4865 Battery Lane</u>	
3. NAME OF DECEASED: (First) <u>Mary</u> (Middle) <u>Louise</u> (Last) <u>York</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan</u> <u>30</u> 19 <u>56</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, <u>DIVORCED</u> (Specify):	8. DATE OF BIRTH: <u>11-21-1909</u>
9. AGE last birthday: <u>46</u> yrs		IF UNDER 1 YEAR: Months <u>2</u> Days <u>9</u>	IF UNDER 24 HRS: Hours <u>3</u> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Administrative Asst</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>N.I.H.</u>	11. BIRTHPLACE (State or foreign country): <u>Rome, Georgia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME: <u>Isham Rhone Walker</u>	
14. MOTHER'S MAIDEN NAME: <u>Zollie Johnson Hunt</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Sister Clara Walker</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Massive Subarachnoid Hemorrhage</u>			<u>3 hours</u>
ANTECEDENT CAUSE (B) <u>Ruptured Congenital Aneurysm</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Right carotid artery</u>			<u>2 years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>1:30 10^{PM}</u>	
22. I hereby certify that I attended the deceased from <u>8:00 PM</u> , 19 <u>56</u> , to <u>1:30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/30</u> , 19 <u>56</u> , and that death occurred at <u>10^{PM}</u> , M, from the causes and on the date stated above.			
SIGNATURE <u>Charles E. Engeling M.D.</u>		ADDRESS <u>4928 St Elmo Ave</u> DATE SIGNED <u>1/30/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial-Transit</u>		DATE THEREOF <u>2-1-56</u>	
NAME OF CEMETERY OR CREMATORY <u>Riverside Memorial Pk</u>		LOCATION (City, town, or county) (State) <u>Jacksonville Florida</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2/4/56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	
24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>		ADDRESS <u>Bethesda, Md</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

NO 10 1

3 3

736
CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Wash. D.C.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <u>TAKOMA PARK</u>				OR TOWN <u>47X-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington San. + Hospital</u>				STREET ADDRESS (If rural give location) <u>918 Farragut Street</u> ✓			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Maurice (none) Yockelson</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>January 15 1956</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>March 15, 1895</u>	
9. AGE last birthday <u>60</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Salesman</u>		11. BIRTHPLACE (State or foreign country): <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME: <u>Abramam Yockelson</u>				14. MOTHER'S MAIDEN NAME: <u>Rebecca Goldstein</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Unknown</u>				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>Acute coronary insufficiency</u>		
ANTECEDENT CAUSE (S) (B) <u>Coronary Thrombosis with</u>		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(C) <u>myocardial infarction</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 12, 1956, to Jan. 15, 1956, that I last saw the deceased alive on January 15, 1956, and that death occurred at 3:55 P.M., from the causes and on the date stated above.

SIGNATURE <u>Claron H. Traim</u>	ADDRESS <u>M.D. 8237 Georgia Ave - Silver Spring Md</u>	DATE SIGNED <u>Jan 15 56</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>1/15/56</u>	NAME OF CEMETERY OR CREMATORY <u>Shelton</u>
LOCATION (City, town, or county) <u>Wash. D.C.</u>	(State) <u>DC</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Jan-15-1956</u>	REGISTRAR'S SIGNATURE <u>William Nodde</u>	24. FUNERAL DIRECTOR <u>B. Damarsky</u>
ADDRESS <u>1111 N. 1st St. Wash. D.C.</u>		

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 17 1956

RECEIVED

887

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Montg</u>		STATE <u>Maryland</u>		COUNTY <u>Montg</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<u>X</u> TOWN <u>Gaithersburg</u>		<u>23 yrs</u>		TOWN <u>Gaithersburg</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>14 E. Diamond Ave</u>							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Louis</u> (Middle) <u>E. McComas</u> (Last) <u>Younkins</u>				(Month) <u>Jan</u> (Day) <u>31</u> (Year) <u>19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Apr 30-1887</u>	<u>68 yrs.</u>	Months <u>7</u>	Days <u>1</u>	Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Retired U S A Institute of Health.</u>		<u>Frederick Co. Md.</u>		<u>U S A</u>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John W. Younkings</u>				<u>Elizabeth Reeder</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>L. Renold Ypunks. Gaithersburg</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE (A) <u>Suba Cranial Hemorrhage</u>				<u>Months</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio sclerosis - Genl.</u>				<u>Years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>1 Renoidal left heart disease</u>				<u>Twenty</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar 15</u> , 19 <u>56</u> , to <u>Jan 31</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 15</u> , 19 <u>56</u> , and that death occurred at <u>6:45</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Jack Schumacher</u>		M.D. <u>Gaithersburg, Md</u>		DATE SIGNED <u>2-1-56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2-2-56</u>		<u>Middletown Cemetery</u>		<u>Middletown Md,</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Feb 2/56</u>		<u>Abraham G. Coale</u>		<u>ERNEST C. GARTNER.</u>		<u>Gaithersburg/ Md,</u>	

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

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NOTIFICATION

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH. IT IS TO BE FILED IN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, BUREAU OF VITAL STATISTICS, WASHINGTON, D. C. 20495. IT IS TO BE FILED IN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, BUREAU OF VITAL STATISTICS, WASHINGTON, D. C. 20495. IT IS TO BE FILED IN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, BUREAU OF VITAL STATISTICS, WASHINGTON, D. C. 20495.

BUREAU V. S.

FEB 19 1956

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